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The Journal OF THE FLORIDA MEDICAL ASSOCIATION

Vol. XLIII JULY, 1956 No. 1

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House of Delegates Actions

Scientific Assemblies

General Sessions

THE NEW YORK ACADEMY OF MEDICINE
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President's Address
John D. Milton

MEDICAL DISTRICT MEETINGS, OCTOBER 30 - NOVEMBER 2

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2. Zimmerman, F. T.: *New York J. Med.* 55:2338, 1955.

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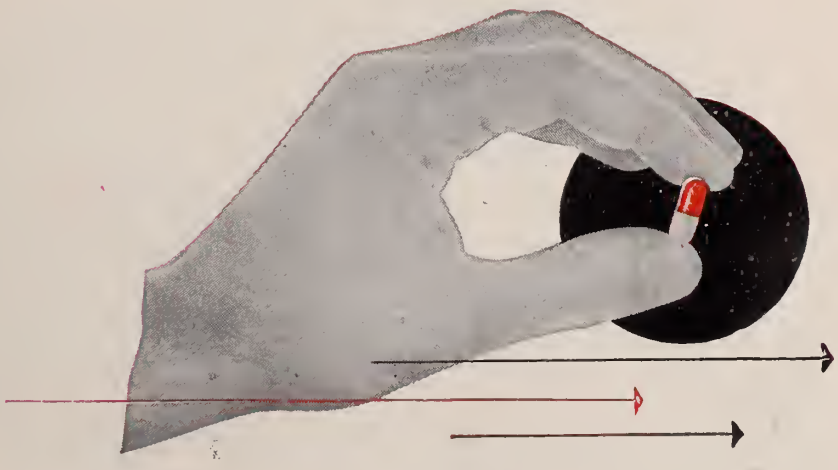
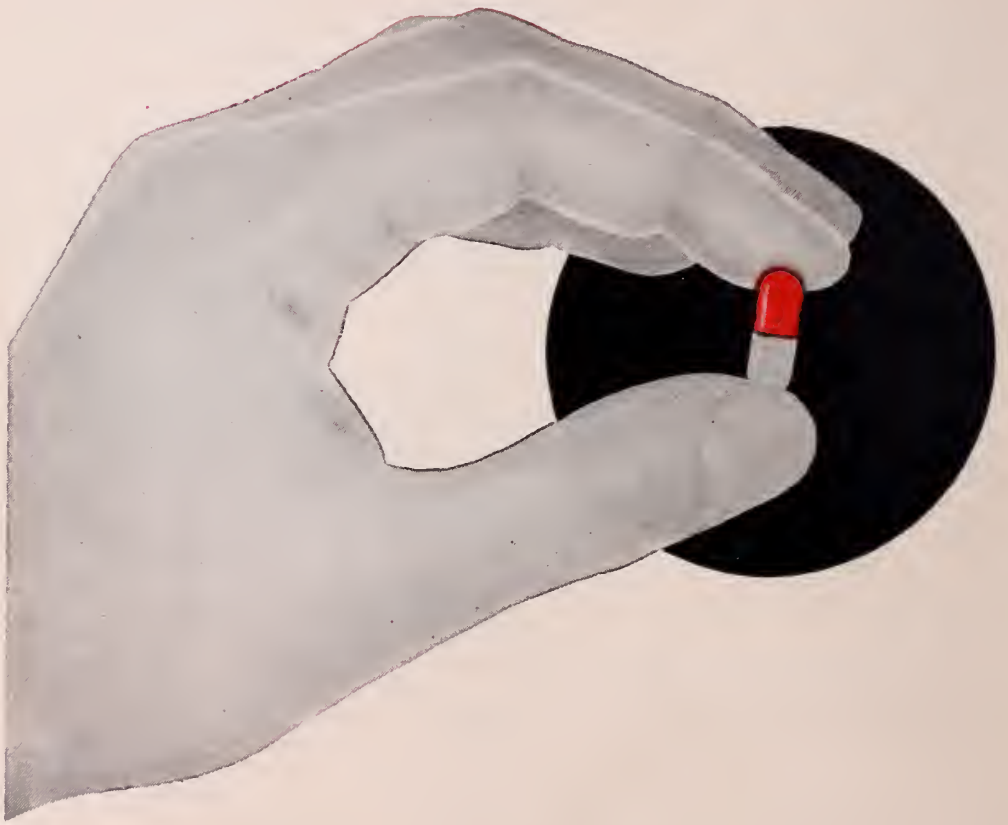


to overcome specific infections that do not respond to any other antibiotics.[1,2,3]

New...



Today's resistant pathogens are the tough survivors of a dozen widely used antibiotics. Certain organisms, notably *Staphylococcus aureus*[4] and susceptible strains of *Proteus vulgaris* produce infections which have been resistant to *all* clinically useful antibiotics.

To augment your armamentarium against these resistant infections, 'Cathomycin' (Novobiocin, Merck), derived from an organism recently discovered and isolated in the Merck Sharp & Dohme Research Laboratories[1], is now available.

SPECTRUM—'Cathomycin' [1,2,3,5,6] has also been shown to be active against other organisms including—*D. pneumoniae, N. intracellularis, S. pyogenes, S. viridans and H. pertussis*, but clinical evidence must be further evaluated before 'Cathomycin' can be recommended for these pathogens.

ACTION—'Cathomycin' in optimum concentration is bactericidal. Cross-resistance with other antibiotics has not been observed.[7]

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SUPPLIED: 'Cathomycin' Sodium (Crystalline Sodium Novobiocin, Merck) in capsules of 250 mg., bottles of 16.

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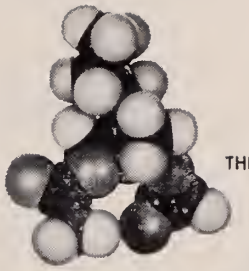

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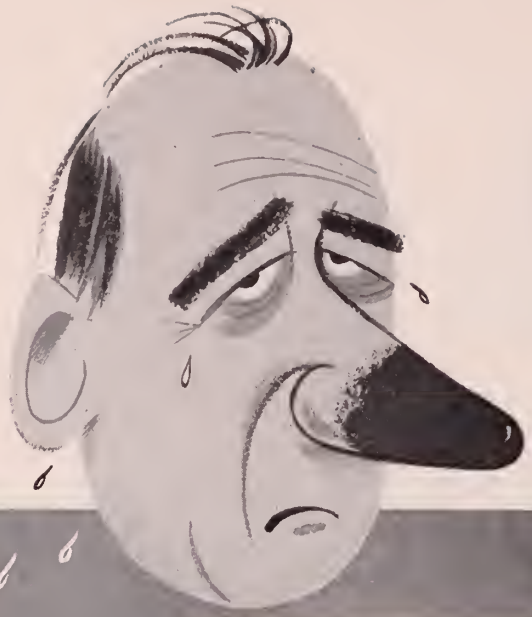

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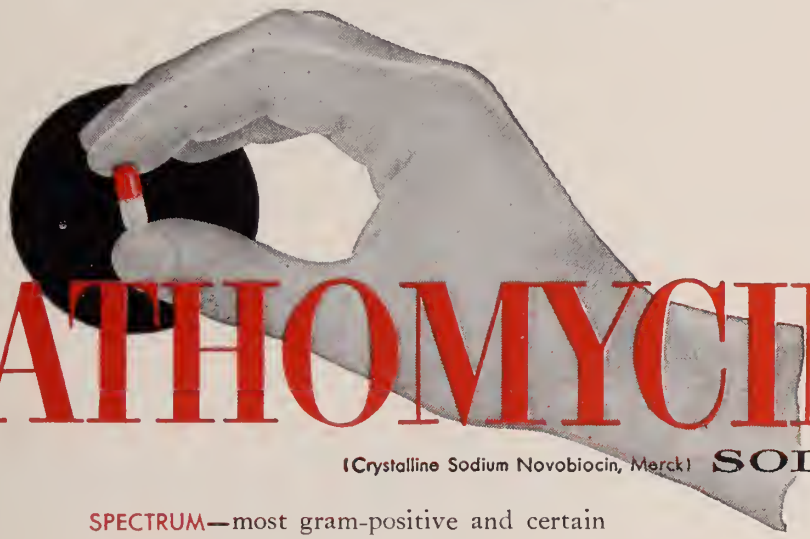

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*T.M.

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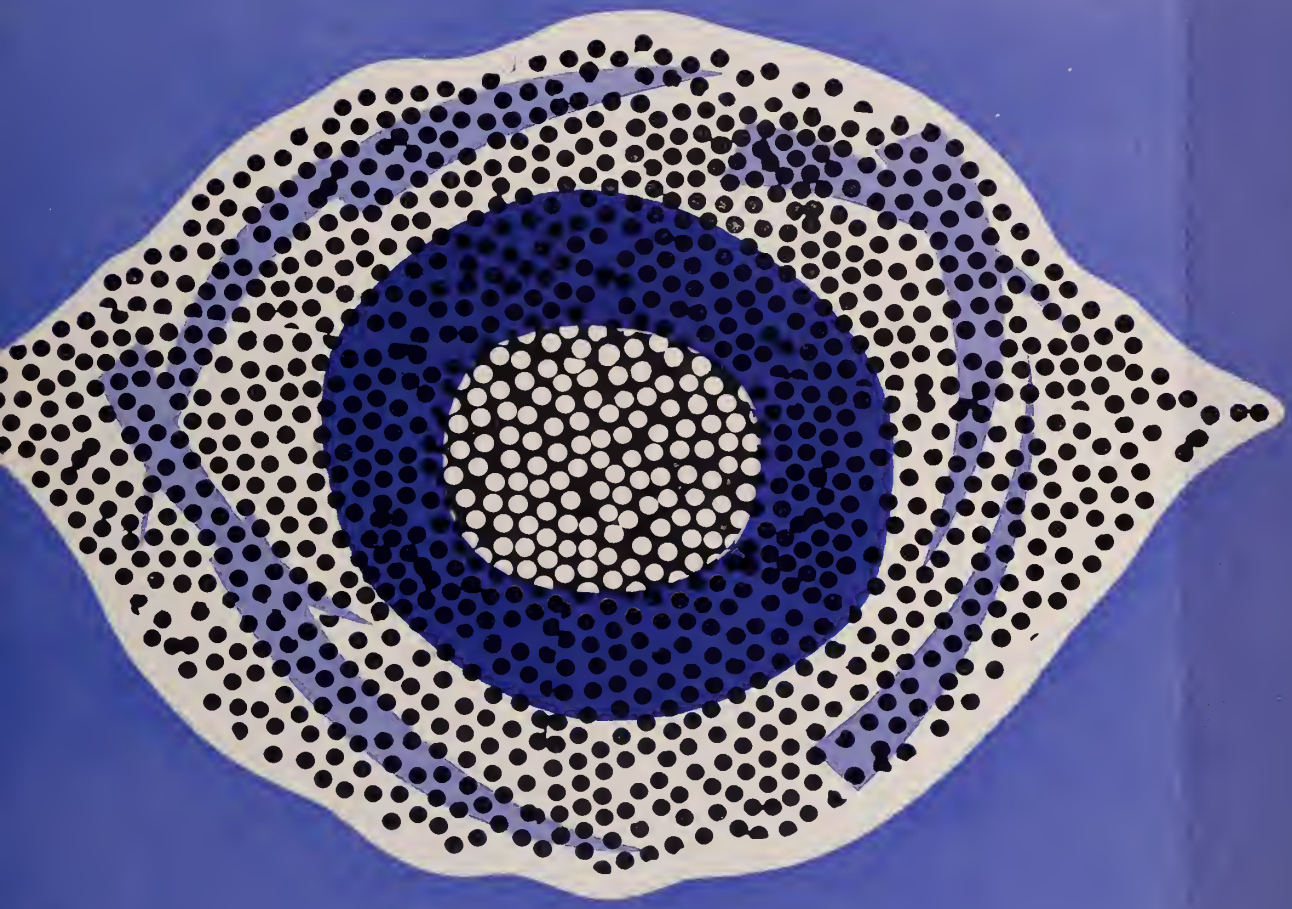

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The Journal of The Florida Medical Association
PUBLISHED MONTHLY

Volume XLIII | Jacksonville, Florida, July, 1956 | No. 1

President's Address

John D. Milton, M.D.
MIAMI

Two years ago you bestowed upon me your highest honor, for which, last year, with fear and great trembling I thanked you. Fear, for I knew of the tremendous tasks that lay before me. Trembling, because I was filled with excitement, joy and emotion for the faith and confidence that you had in me that I could perform the duties of this high office for you and the Florida Medical Association. Now, as my year is fast coming to a close, I again wish humbly to express my appreciation for the privilege of serving this great Association. Much of the work which we endeavored to do was spurred on by a verse from Proverbs which was impressed upon me by my father. It is most excellent, and I recommend it to you: "Keep thy heart with all diligence; for out of it are the issues of life."*

Naturally, whether in private practice or serving organized medicine, there are sacrifices. Each physician knows well that to practice medicine in any of its many branches, there are untold sacrifices, made not only by himself but also by the ones close to him. I, therefore, wish to pay tribute to my wife, Rheda, for all the inconveniences of cancelled social engagements, delayed dinners, half-finished shows or concerts, sleepless nights, and outings that of necessity had to be changed. Knowing all this, and being cognizant of all the work being accomplished by our ladies of the Auxiliary, I wish to pay tribute to the entire Auxiliary under the leadership of Mrs. Samuel S. Lombardo, because I know they are for us and will back us — win, lose or draw. So, Gentlemen, in the words of the Prophet I call upon you to "exalt her and she shall promote thee; . . . ."

To the members of the Board of Governors I am deeply indebted for their excellent cooperation and wise counsel throughout the year. They are to be commended for their conscientious, unselfish service and the efficiency with which they have carried on the work of the Association during the period of my administration. Very few realize the amount of time expended and the personal financial loss on the part of the members of the Board of Governors in order to carry out the dictates of the House of Delegates. This they gladly do for all of you. I extend to them my sincere thanks and appreciation.

It has been a privilege to have the loyal support of the officers and to observe the many evidences of their keen interest in the Association's welfare. Our Secretary-Treasurer, Dr. Samuel M. Day, has been most generous with his time and tireless in his efforts on behalf of the Association. Residing in close proximity to headquarters, he makes himself available at all times and attends to the manifold duties of his important office diligently and meticulously.

Public Relations

Liaison for the Board of Governors with regard to Public Relations was firmly established last year and has been more closely cemented this year. Dr. Edward Jelks, through the years a pillar of strength in the Association, has served with great distinction as the Board's representative to direct and oversee the Association's comprehensive long range public relations program adopted by the House of Delegates in 1954. In this difficult and delicate task he has utilized most effectively the wisdom he has acquired through his broad experience and sound judgment born of keen perception and an understanding heart. These qualities, coupled with the charm of his magnanimous personality, have enabled him to render invaluable service to the Association. Ably assisted by the Public Relations Bureau, Dr.

*Proverbs 4:23.

Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami Beach, May 15, 1956.

Jelks has expedited the public relations program throughout the state, traveling countless miles and giving unstintingly of his time and effort. Ample evidence of improved and increasing public relations activities, manifest throughout all districts, attests the progress made in this vital field.

Legislation and Public Policy

The heavy responsibilities placed upon the Committee on Legislation and Public Policy demand the ceaseless activities which characterize this committee. Dr. H. Phillip Hampton, its Chairman, has contributed outstanding leadership. He has been diligent both in guarding and in promoting the Association's legislative interests, not only in Florida, but also nationally. The success of the voluminous activities of this committee in furthering a constructive legislative program is apparent in the renewed interest and cooperation rendered by the county medical societies prior to and during the last legislative session, and more recently, in preparation for the next session. During the year now closing the Association's strategic position, enabling it to provide medical guidance and counsel on health matters, has been materially strengthened through the cultivation of closer relationships with state officials and agencies. Dr. Hampton and his committee have won the deep gratitude of the officers and the entire membership for their valiant efforts and complete devotion, over and above the call of duty, to the demanding task confronting them. At great personal sacrifice, he and his committee have made a notable and lasting contribution. They have been aided in the laborious undertaking by the Public Relations Bureau, which has constantly given expert assistance.

Medical Economics

Another particularly active group deserving special commendation is the Committee on Medical Economics, headed by Dr. Robert E. Zellner. The vast amount of time and hard work expended by this committee have been directed during the year to a continuing effort to obtain a satisfactory professional liability insurance group policy upon the basis of the sound plan the Association has proposed, but to no avail. The work, however, has brought forth a disability plan that seems to be good. The Board recommends it to you for your action.

Scientific Work

The excellent scientific program arranged for this meeting bespeaks the activity of the Committee on Scientific Work. Dr. Donald F. Marion, its Chairman, and his committee have been painstaking in their efforts to present to the members a balanced and varied program. With the steady growth of the Association, the task of selection from the increasing number of papers submitted becomes more and more exacting and time-consuming. This committee is to be congratulated upon the excellent manner in which it has functioned.

The Council

The Council, under the chairmanship of Dr. Ralph W. Jack, has discharged its duties throughout the year with distinction. The scientific programs for the District Meetings featured symposiums on subjects of wide general interest, and much enthusiasm was exhibited. The Chairman and the individual Counselors have given excellent leadership in their respective Districts for which I commend them.

Other Committees

The activities of the numerous other committees are likewise to be lauded. They, too, have performed their duties well, the degree of activity in each instance depending upon the nature of their assignments. To the chairmen and to the members of all of the committees, I wish to express genuine appreciation of their services.

The Journal

The Association is indebted to Dr. Shaler Richardson, the Editor, and to the Assistant and Associate Editors for the success of its official publication. Through the many years of his faithful service, Dr. Richardson has seen The Journal progress steadily to its present high rating among state medical publications. The Editor's report in the July issue will be of interest to all the members. The cooperation of the entire membership is earnestly sought so that The Journal may continue to fulfil its mission of service. Contributions by the members to the scientific section, the featured department of The Journal, are most welcome — keep them up. News of personal interest and other suitable items are also welcome.

Permanent Home

I would certainly go amiss if I failed to mention one of the most active committees that has been in existence for the past 12 months. The Building Committee, a subcommittee to the Board of Governors, moved without delay quietly and efficiently, as soon as the House of Delegates ap-

proved the building of our permanent home in Jacksonville.

Negotiations were started for a building site and land was purchased within a matter of days. A wrecking company demolished the old building that was on the property, paying the Florida Medical Association for the privilege. Architects were obtained, plans were approved by the Board, blue prints were prepared, the contract was let, and in quick succession the engineers, masons, structural steel workers, carpenters, and others worked progressively until our permanent home is now nearing completion. The credit for this smooth operation is due solely to the committee for continually driving to get this work done; therefore, I wish to express my deepest appreciation and thanks to Drs. Edward Jelks, Robert B. McIver, and Samuel M. Day.

I am sure that if Dr. Gerry R. Holden, a beloved past president, were with us today, he would say, "My dream is fast coming into being."

Executive Office

The staff of the Executive Office in Jacksonville is charged with the surprisingly intricate task of keeping the wheels of the Association turning. The many ramifications of this procedure and their expeditious handling merit fuller understanding and due appreciation by the membership at large. The Managing Director, Mr. Ernest R. Gibson, mans the helm of the Association's business with quiet dignity and dispatch. Alert, efficient and cooperative, he commands the warm regard, not only of the officers and Board members, but also of all in the Executive Office.

The Assistant Managing Director and Supervisor of the Public Relations Bureau, Mr. W. Harold Parham, guides the Bureau's specialized work with fitness and decorum. Whether within his office or in the legislative halls, he meets people with ease and grace and catalogues their words and actions with amazing accuracy.

I pay high tribute to Mr. Gibson and Mr. Parham.

Mr. Thomas R. Jarvis, Director of Publication; Mr. Eugene L. Nixon, Assistant Supervisor of the Public Relations Bureau; Mrs. Zoe Pack, Officer Manager; Mrs. Mae W. Mason, Secretary to the Board, and the remainder of the office staff, you have my sincere thanks and appreciation.

Perspective

Now in the simple language of a Negro minister who uttered a prayer which is most apropos, "Oh, Lord, fill my mouth with worthwhile stuff and nudge me when I've said e'nuff."

Being an officer of an association gives a man some privileges and responsibilities which he would not ordinarily have. I recall back in 1949 when I was President of the Dade County Medical Association, the rude awakening I had upon becoming more intimately acquainted with the inner workings of a grass roots level medical organization. Although I had served in other capacities since becoming a member of DCMA, almost 30 years ago today, it was only when I became its president that I fully realized the many problems which organized medicine on the county level must face.

On assuming the office of President-Elect of the Florida Medical Association, I began to realize more and more the tremendous responsibilities which the state organization has and the portion of this obligation which must be shared not only by the officers and Board members, but by the *individual physician.*

During the past two years, it has been a pleasure to observe the great amount of coordination that must exist between county societies and the state office and which actually does exist. It is amazing to discover the great degree of diversification which occupies the time of the employees in our Executive Office. There you learn that Florida Medical Association committees are not just names in The Journal, but instead, are groups of men who are actually involved in a considerable amount of work representing almost every conceivable interest which medicine has on both a public health and economic level.

As your President, it has been my privilege to attend meetings of the American Medical Association and to visit its headquarters office in Chicago. Actually, I should have taken this same opportunity long ago as an individual member of organized medicine and I certainly hope that each of you will do so whether or not you ever have the honor of serving as President of the Florida Medical Association. As you observe the difference between the function of the county organization and the state association, you will also notice the vast difference between the activity in the AMA office and that of the state office for the interests there are even that much more diversified.

All this activity on the part of medical organizations, however, is paradoxical. On the one hand, you have an association made up of individuals who are striving every day to do the good

and positive things which all of us feel are necessary for the preservation of good health and the security of our profession. On the other hand, you realize that the very necessity of such activity by the vast majority of our individual members is the action of a small handful of our members who at times apparently are content to turn their backs on public reaction to serious problems whether they are scientific or economic, but which have great bearing on the attitude of the public towards our profession.

At this point I would like to say that the experiences which I have had these last two years have led me to believe that long range planning is certainly a definite requirement of our Association; therefore, I recommended to the Board of Governors that an Executive Committee be established within the Board which will be charged with many responsibilities. One is that of mapping long range plans for the Association — plans which may take four, five or 10 years to materialize, but which, at least, keep us headed in the right direction.

Blue Cross – Blue Shield

As we learned through publications which we all receive, there is a tremendous increase in the health insurance field. This brings to mind our own Blue Shield program. A recent publication of the Florida Business Letter indicates that since 1940 through the year 1954, premiums paid by Florida citizens alone for accident and health insurance have increased more than 4,733 per cent. I would like to repeat that so there will be no misunderstanding — have increased more than 4,733 per cent since 1940. Florida residents paid $1,266,000 in premiums for accident and health insurance in 1940. By 1954 this amount had increased to more than $60,000,000. Such a tremendous stride forward has also been experienced by Blue Shield. Now that the delegates to the Florida Medical Association from the various county medical societies are also the active members of the Blue Shield plan, it behooves each of us to become vitally concerned with our deep responsibility, not only to our fellow physicians, but more importantly to the great number of citizens of this area who are dependent upon Blue Shield when sickness strikes. We dare not overlook our responsibilities in this direction.

Corporate Practice of Medicine

There are many other problems of the individual practitioner of medicine which have great bearing on matters of economic stress and strain. Years ago our prime battle line was against the threats of socialized medicine, which we still have, as witnessed by the AMA Washington Newsletter of April 20. But today, perhaps the most important and most disturbing to all of us who have tried to predict what is ahead in the way of serious threats is the problem of the corporate practice of medicine. Each of us has read various reports on the problems which hospitals and physicians faced in Iowa in the recent suit between members of the medical profession and hospital administrators in that state. More serious, however, to me, seems to be the threat which is posed by the corporate practice by organizations other than hospitals, for we then begin to talk about groups whose first aim is not in the health field. For example, a recent announcement in the Miami Herald disclosed plans by organized labor in Dade County to construct a 150 bed hospital designed to meet what the members of organized labor refer to as an inequity between health insurance benefits and their ability to pay. As the spokesman for the group stated, "We feel certain that this inequity can be eliminated in a hospital run by and for organized labor." The article also stated, "Quite a few physicians have indicated that they would be willing to serve full time at labor's own hospital." Needless to say, the adverse experience which the Health Insurance Plan of New York City, commonly referred to as "HIP," has recently had, should indicate to labor that it should tread very cautiously in setting up a panel of physicians on a full time basis.

I am reminded of a quotation from Ibycus, "You cannot find a medicine for life once a man is dead." Gentlemen, I would like to twist that a bit and warn, "You cannot find a cure for *corporate* practice after *private* practice is dead."

Close on the heels of the threat posed by labor is that presented by management itself. Many industries throughout Florida have now engaged the services of some of our finest physicians as medical directors of their industrial health units. Needless to say, so long as these units are restricted to what is presently considered to be the function of an industrial health department, we will have no worry. As the cost of health insurance increases to management, however, there will be ever increasing pressure to deviate from the established practice of most of our highly acceptable industrial health units to begin to use them on a corporate practice basis in direct competition

with the private physicians of the area. Our relations with both labor and management require that the shortcomings of this approach to a major problem far outweigh the advantages which seem to appear on the surface.

As Cicero said, "Thus, in the beginning, the world was so made that certain signs came before certain events." I say to you that the signs are clearly before us *today* and the events will surely follow tomorrow unless we act now.

While on the subject of the corporate practice of medicine, we cannot help but think of our two medical schools and we immediately realize that we are dealing with a very sensitive problem. On the one hand, we are strongly in support of medical education in its every phase and certainly we have demonstrated our cooperation with the two universities which have organized medical schools in our state. We are not at all concerned, therefore, with our position with respect to supporting these organizations. This has been made very clear.

At the same time, however, we are expected, not only by the members of our profession, but by the public and educators, to safeguard the ultimate success of these two fine schools by making certain that the manner in which they conduct their policies is in accordance with the best interest of all concerned and more particularly than anyone else, the general public of our area. In this respect, it should be realized that a statement in the autobiography of Dr. Lewis J. Moorman, which was brought to our attention by Dr. R. L. Sanders, then President of the Southern Medical Association, is most important. He said, "In a broad sense, the welfare of the world is within the purview of the medical school." Since the character of formal training received by the student will largely serve as a pattern throughout his professional life, it is obvious that the welfare of the world can best be served if this training includes every phase of medical practice. Surely young medical students should be brought up, so to speak, in the proper atmosphere for they are the physicians of tomorrow and the members of the House of Delegates of the Florida Medical Association day after tomorrow.

Realizing this some time ago, the Board of Governors contributed to defraying the expenses of sending a representative from the University of Miami to the Student American Medical Association. In September we will have not only the University of Miami, but also the University of Florida, with its medical school. I recommend to the House of Delegates, therefore, that we contribute an equal amount to each school and the amount be set up in the budget annually, not to exceed $300 to each school.

Other Problems

As we mentioned, the corporate practice of medicine is just one of the problems which face us today. Each of our members is confronted with numerous other situations. Perhaps paramount among these is the physician's relationship to the individual patient. The excellent public relations program, a report of which will be presented to you as a portion of the supplemental report of the Board of Governors, indicates the many suggestions and services available to the physician in creating a better relationship between him and his patient. In spite of all of the reports which are made, however, the ultimate success of those who make them is dependent entirely upon the individual physician.

In addition, the doctor of today must be concerned with his relationship to the public as a whole. *In other words, he must be a citizen as well as a physician.* He must take part in civic activities; he must be a member of some service organization; he must acknowledge the needs of his church, the local Community Chest, and the Chamber of Commerce, to mention but three. More important than all, he must take an active interest in politics, for nothing is more vital to the public than to have the medical profession on guard where political involvement in health matters is concerned. Lastly, the individual physician's relationship to other practitioners is most important. Mere adherence to some printed set of principles such as the Principles of Ethics of the American Medical Association is not in itself enough. If the physician does not have in his heart the desire to associate with his colleagues in a gentlemanly fashion, all of the principles and codes which we could design would be to no avail.

The responsibility of organized medicine to medical education is well defined, and I believe each of us has his own clear concept of this duty. Perhaps in detail we differ, but I am sure there is no question but that each physician in this room and each of the many physicians which we represent, stands strongly behind any program which is designed to advance medical education, increase the caliber of graduates and improve the health of our nation. Yet at the same time, we must require that the teachers in these medical

institutions, who have such a tremendous responsibility, furnish us with graduates who have a basic understanding for human problems and for the things which make everyday life that which it is.

If we, as physicians, extend our fullest cooperation to the medical educators of this county, and more particularly to the medical educators in the two universities in our state which now have medical schools, we should do so with proper spirit. We should, on the one hand, constantly require of the educator that he do everything in his power to make available to the student the finest methods and material of which modern education is composed. At the same time we must realize that he is the educator, he is the teacher, he is the man who does not leave the classroom or the hospital and go back to his everyday practice of medicine, but instead, is faced with planning for tomorrow's classes, helping students with financial problems and dealing with many of the situations which you and I recall when we, too, were students. The educator's outlook, therefore, must be somewhat different from ours. Yet, we both must remember that we each are physicians and are headed in exactly the same direction. The educator needs our leveling viewpoint as private practitioners of medicine, the same as we need his, and further, the student must know both sides because the greater number will be in private practice. The closer we can make our roads parallel to each other through attempts at understanding and through conferences in an effort to work out our problems, the sooner we will find that we are traveling down the same path which will enable us to reach our goal more easily.

I have received the nudge. In conclusion I would like to impress upon you to protect your heritage, "The Private Practice of Medicine." You are pushed from without and within by two major forces — the advocates of socialized medicine on the one hand and the corporate practice groups on the other. So be ever on the alert and

Do all the good you can,
By all the means you can,
In all the ways you can,
In all the places you can,
At all the times you can,
To all the people you can
As long as ever you can.

ABSTRACTS

The Treatment of Inoperable Prostatic Carcinoma with Radioactive Gold. By Miles W. Thomley, M.D., Louis M. Orr, M.D., and James L. Campbell, M.D. South. M. J. 49:146-148 (Feb.) 1956.

Although the radioisotope Au 198 is becoming more widely used in the treatment of certain malignant tumors, its application must still be considered in the experimental stage. Nevertheless, these authors regard the results as worthy of careful evaluation and report a series of 62 cases in which they used Au 198 in the treatment of advanced carcinoma of the prostate with encouraging results. The patients in this series were selected from that group which could not be cured by radical prostatectomy and yet showed no evidence of distant metastasis. They believe the remarkable sensitivity of many of these neoplasms to this radioactive isotope should be further developed to increase the longevity and perhaps the curability of the host of patients afflicted with this disease for whom, at the present time, no other treatment offers hope for relief.

Diffuse Indolent Pulmonary Tuberculosis. By Howard A. Buechner and Augustus E. Anderson. Am. Rev. Tuberc. 71:503-518 (April) 1955.

The authors describe a diffuse indolent form of pulmonary tuberculosis, designated in the past as "chronic productive tuberculosis." They observe that either because of confusion related to the exact implications of this term or because of a present day tendency to apply it loosely as a designation of fibrotic residuals of inactive tuberculosis, a somewhat limited awareness of this specific clinicopathologic entity appears to exist. Accordingly, they prefer to substitute "diffuse indolent pulmonary tuberculosis" for the older term. This phrase seems both appealing and appropriate to them since diffuse indicates the tendency toward widespread pulmonary involvement and indolent describes the leisurely manner in which the disease process browses downward through the lungs over a period of many essentially symptomless years. They present four illustrative cases.

A Histochemical Study of Breast Carcinoma. By Alvan G. Foraker, M.D. Surg., Gynec. & Obst. 102:1-8 (Jan.) 1956.

As a contribution to knowledge of breast carcinoma, tissue from 22 patients with carcinoma of the breast and examples of normal breast tissue from the same or other patients were subjected to a battery of histochemical technics including localization of dehydrogenase, alkaline phosphatase and phosphamidase activity, glycogen, protein-bound sulfhydryl and disulfide groups. The carcinomatous tissue was compared with the non-neoplastic breast tissue.

Evidence of dehydrogenase activity, sulfhydryl and disulfide groups, was found in normal and carcinomatous cells. Glycogen deposition was stronger and more uniform in normal epithelium, but occurred in carcinoma, including some examples of poorly differentiated breast carcinoma. Alkaline phosphatase reaction was weak in normal and absent in neoplastic epithelium. Phosphamidase reaction in general was stronger in carcinoma than in normal epithelium. No histochemical reaction pattern peculiar to carcinoma was observed.

Treatment of Toxic Adenomatous Goiter by Large Doses of Radioactive Iodine. By James R. Cook, M.D., Robert W. Jones, M.D., and E. Perry McCullagh, M.D. J. Clin. Endocrinol. 15:1512-1517 (Dec.) 1955.

A series of cases is reported in which 31 patients having toxic adenomatous goiters, who had either refused surgery or were considered poor surgical risks, were treated with large initial doses of radioactive iodine. Twenty-one received an initial dose of 20 to 40 millicuries, and 10 received an initial dose of 50 millicuries or more.

In 23 of these patients the hyperthyroidism was controlled within four months. Following an initial dose of 50 millicuries or more, the hyperthyroidism appeared to be controlled more promptly and effectively than following a smaller initial, or a smaller repeated dose.

In no instance was the cardiac status aggravated by treatment. In some patients the initial therapy did not control the hyperthyroidism, but further treatment with radioactive iodine resulted in a euthyroid condition. In others the thyroidal uptake of radioactive iodine was too low, despite persistent thyrotoxicosis, to warrant repeated administration. The authors concluded that radioactive iodine should be given first consideration when treatment other than surgery is to be used in toxic multinodular goiter.

Histochemical Studies of Skin: Localization of Dehydrogenase Activity. Protein-Bound Sulfhydryl and Disulfide Groups. By Alvan G. Foraker, M.D., and William J. Wingo, Ph.D. A. M. A. Arch. Dermat. & Syph. 72:1-6 (July) 1955.

The occurrence and distribution of succinic dehydrogenase activity and of protein-bound sulfhydryl and disulfide groups, all having relationship to growth, metabolism, or maturation of epidermal cells, were studied in 102 specimens of human skin. The results were as follows:

1. Sulfhydryl groups and dehydrogenase activity, both related to vital phases of cell function and growth, were found in viable epidermal cells, in sweat glands, sebaceous glands, and in hair root sheath layers.

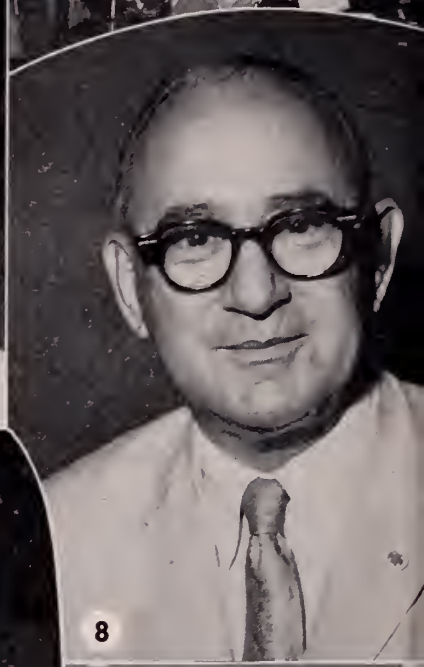
2. Disulfide groups, related to cell keratinization, were found in keratinizing epidermal cells and in hair shafts.

Proctosigmoidoscopy as a Routine Procedure. By William Wickman, M.D., D.A.B.S., A.I.C.S., and Timothy A. Lamphier, M.D., D.A.B.S., F.A.C.S., F.I.C.S. J. Internat. Coll. Surgeons 24:89-96 (July) 1955.

The purpose of this paper is to urge the more frequent use of proctosigmoidoscopic study as a routine procedure in all physicians' offices. The authors emphasize its great importance as a routine procedure in detecting cancer of the rectum, which is the second most frequent malignant disease in the male and the fourth most frequent in the female. They state that roentgen examination is totally inadequate for lesions of the terminal 5 to 6 inches (12.5 to 15 cm.) of the large intestine.

They describe the common positions for sigmoidoscopic study and point out the advantages of each. Also, they find a useful aid in the apparatus used by Swinton of the Lahey Clinic, which facilitates sigmoidoscopic study and does away quickly with disagreeable fecal odor and fecal water in the large intestine. In the study of low back pain and pelvic pain, the sigmoidoscopic procedure is of paramount importance in their opinion.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.



REGISTRATION DESK

Proceedings
Eighty-Second Annual Meeting

Florida Medical Association
Miami Beach, May 14-16, 1956

GENERAL SESSIONS

First General Session

The Eighty-Second Annual Meeting of the Florida Medical Association was called to order at 9:00 a.m., Monday, May 14, in the La Ronde Room of the Hotel Fontainebleau, Miami Beach, Florida, by President John D. Milton.

Invocation was pronounced by The Reverend Lewis N. Head, D.D., Pastor of the Coral Gables Methodist Church, Coral Gables.

Dr. Hunter B. Rogers, President of the Dade County Medical Association, gave the official welcome of the county society, and introduced The Honorable Harold Spaet of the City of Miami Beach who welcomed all members of the Association to the City of Miami Beach and presented Keys to the City to the officers.

Dr. Milton: "It is very unfortunate that we do not have with us this morning Dr. Elmer Hess, President of the American Medical Association, but on his tour through the South he was stricken with an illness and had to be flown back to his home in Erie, Pennsylvania.

"Dr. Dwight H. Murray was also detained by a trip that went in another direction. Dr. Murray is at the meeting of the Medical Association of Georgia this morning, which is convening in Atlanta.

"Are the fraternal delegates from Georgia present?"

The fraternal delegates were not in attendance.

Dr. Milton called attention to the first scientific assembly which was to convene in the same room at 9:30.

There being no further business, the meeting adjourned at 9:20 a.m.

Second General Session

The Second General Session of the Florida Medical Association convened at 12:25 p.m., Tuesday, May 15, in the La Ronde Room of the Hotel Fontainebleau, Miami Beach, with President John D. Milton in the Chair.

Dr. Milton: "Dr. Dwight H. Murray could not attend and sent his regrets for his inability to come, but another engagement in Atlanta with the Medical Association of Georgia detained him.

"We have no further introductions, and I am just going to say to Dr. Cline that we are sorry we ran over so long and sorry he had to wait. There are individuals here who could introduce Dr. Cline far better than I, inasmuch as they have been associated with him for several years in the A.M.A. As you know, Dr. Cline is a Past President of the A.M.A. and has been extremely inter-

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Highlights of the Eighty-Second Annual Meeting

(Opposite Page)

(1) At the annual dinner are (left to right) Mrs. Samuel S. Lombardo and Dr. Lombardo of Jacksonville, Mrs. Francis H. Langley of St. Petersburg, Dr. John D. Milton of Miami, Dr. H. Phillip Hampton of Tampa, Dr. John W. Cline of San Francisco, Mrs. Milton, Dr. Langley and Mrs. Hampton. (2) Dr. Langley, after being installed as president, pins the past president's button on Dr. Milton in a brief ceremony near the close of the final session of the House of Delegates. (3) Dr. William C. Roberts of Panama City addresses the House of Delegates immediately following his election as President-Elect. (4) The House of Delegates deliberates in the La Ronde Room, Hotel Fontainebleau. (5) Dr. Samuel M. Day of Jacksonville receives congratulations following his re-election as Secretary-Treasurer. (6) A partial view of the technical exhibits set up in the Grand Ballroom of the Hotel Fontainebleau. (7) Dr. Cline, the guest speaker, delivers his address on biliary tract surgery. (8) Dr. Shaler Richardson of Jacksonville is shown following his re-election as Editor of The Journal. (9) A lull in registration before the total of 2,091 is reached. (10) At the patio party are (left to right) Mrs. Fred I. Dorman Jr. and Dr. Dorman of Lakeland, Mr. Jack Harris of Orlando and Dr. and Mrs. John E. Daughtrey of Lakeland.

ested in organized medicine. He still is. He is a power in the great State of California, not only in organized medicine, but also in civic affairs and politics and I am sure he is interested nationally. Professionally, in his chosen field of surgery, he is outstanding and I am sure he will present to you an excellent paper at this time."

Dr. Cline: "Thank you very much. It is a great pleasure to be here in Florida with you. There is probably no state in which I have more friends and no place certainly that I would prefer to go than to Florida. It is particularly a pleasant thing to me to be here today to talk in a purely professional capacity. I have been so completely and thoroughly identified with the organizational aspects of medicine that to get back to my first love is very pleasant."

The complete text of Dr. Cline's address on "Biliary Tract Surgery" will appear in a later issue of The Journal.

The meeting was adjourned at 1:40 p.m.

The following telegram was received too late for reading at the Second General Session.

Tallahassee, Fla., May 15, 1956

Dr. John Milton, President
Florida Medical Association
Fontainebleau Hotel
Miami Beach, Florida

DEEPLY REGRET THAT MY WORK SCHEDULE AND COMMITMENTS ARE SUCH THAT I CANNOT ATTEND FLORIDA MEDICAL ASSOCIATION MEETING. BUT APPRECIATE YOUR WANTING ME. PLEASE CONVEY MY GREETINGS TO THOSE PRESENT, AND MY BEST WISHES FOR A MOST SUCCESSFUL CONVENTION. WARM REGARDS.

LEROY COLLINS, GOVERNOR

HOUSE OF DELEGATES

First House of Delegates

The House of Delegates convened at 9:30 a.m., Tuesday, May 15, 1956, in the La Ronde Room of the Hotel Fontainebleau, Miami Beach, Florida, with Dr. John D. Milton, President, in the Chair.

Dr. Ralph W. Jack, Chairman of the Credentials Committee, announced that a quorum was present, 139 delegates being registered. (Subsequent report of the Credentials Committee showed 143 delegates registered.)

Dr. William M. Rowlett of Hillsborough moved that the delegates be seated.

Seconded by Dr. Bryans.

Motion carried.

Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, John E. Maines Jr.

BAY—William C. Roberts

BREVARD—Theodore J. Kaminski, Laurent L. LaRoche

BROWARD—Julius F. Boettner, Russell B. Carson, Burns A. Dobbins Jr., Donald H. Gahagen, Richard A. Mills *(Absent—John H. Mickley)*

COLUMBIA—Laurie J. Arnold Jr.

DADE—Edward R. Annis, Harry E. Beller, Turner E. Cato, Reuben B. Chrisman Jr., Jack Q. Cleveland, Francis N. Cooke, Vincent P. Corso, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Rochard M. Fleming, George Gittelson, J. Raymond Graves, Maurice M. Greenfield, R. Spencer Howell, James J. Hutson, Ralph W. Jack, Walter C. Jones, David Kirsh, Alfred G. Levin, Donald F. Marion, Frazier J. Payton, Frederick P. Poppe, Warren W. Quillian, Hunter B. Rogers, Walter W. Sackett Jr., T. D. Sandberg, Ralph S. Sappenfield, Oden A. Schaeffer, Donald W. Smith, Joseph S. Stewart, William M. Straight, Oliver P. Winslow Jr., Corren P. Youmans

DeSOTO-HARDEE-HIGHLANDS-GLADES — James G. Smith

DUVAL—James L. Borland, Frederick H. Bowen, Hugh A. Carithers, J. K. David Jr., A. Judson Graves, Karl B. Hanson, Arthur L. Hardie Jr., Gordon H. Ira, F. Gordon King, Raymond H. King, Joseph J. Lowenthal, Charles F. McCrory, Kenneth A. Morris, Sidney Stillman, Leo M. Wachtel Jr.

ESCAMBIA—Herbert L. Bryans, Alpheus T. Kennedy, George W. Morse, Walter C. Payne Sr., Gretchen V. Squires

FRANKLIN-GULF—Joseph P. Hendrix

HILLSBOROUGH—H. Phillip Hampton, Eugene B. Maxwell, David R. Murphey Jr., Wade C. Myers Jr., Julien C. Pate Jr., James N. Patterson, Madison R. Pope, William M. Rowlett, Edward F. Shaver, Robert W. Withers

INDIAN RIVER—William L. Fitts 3rd.

JACKSON-CALHOUN—James T. Cook Jr.

LAKE—Sanford C. Colley

LEE-CHARLOTTE-COLLIER-HENDRY—Earl S. Davis, William H. Grace

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON —Francis T. Holland, George H. Massey, Robert H. Mickler

MADISON—*(Absent—Candler K. Hayes)*

MANATEE—Millard P. Quillian

MARION—Henry L. Harrell

MONROE—Ralph Herz

NASSAU—Benjamin F. Dickens

ORANGE—Frank C. Bone, Chas. J. Collins, Carl S. McLemore, Louis M. Orr, Frank J. Pyle, Charles R. Sias, W. Dean Steward, Robert L. Tolle, Robert E. Zellner

PALM BEACH—Edwin W. Brown, C. Jennings Derrick, V. Marklin Johnson, Ralph M. Overstreet Jr., Cecil M. Peek, Raymond S. Roy *(Absent—Walter R. Newbern)*

PASCO-HERNANDO-CITRUS—S. Carnes Harvard

PINELLAS—Clyde O. Anderson, Curtis W. Bowman, Elmer B. Campbell Sr., Harry R. Cushman, N. Worth Gable, Percy H. Guinand, Daniel F. H. Murphey, John P. Rowell, James E. Thompson, Walter H. Winchester, Rowland E. Wood

POLK—Jere W. Annis, James R. Boulware Jr., Marion W. Hester, James T. Shelden, Edgar Watson

PUTNAM—Lawrence G. Hebel

ST. JOHNS—Reddin Britt

ST. LUCIE-OKEECHOBEE-MARTIN—Richard F. Sinnott

SARASOTA—John M. Butcher, Hugh G. Reaves, Melvin M. Simmons

SEMINOLE—Terry Bird

SUWANNEE—Edward G. Haskell Jr.

TAYLOR—Charles R. Wiley

VOLUSIA—C. Robert DeArmas, William R. Hutchinson, Howard W. Reed *(Absent—Theodore F. Hahn Jr.)*

WALTON-OKALOOSA—Frederic E. Caldwell

WASHINGTON-HOLMES—*(Absent—Martin L. Lane)*

STATE OFFICERS—John D. Milton, Francis H. Langley, Thomas C. Kenaston, Sidney G. Kennedy Jr., Walter E. Murphree, Samuel M. Day, Shaler Richardson

Dr. Milton announced that his parliamentarian, Dr. George F. Schmitt Jr., was present.

On motion by Dr. Ralph Herz, seconded by Dr. Jack Q. Cleveland, and carried, the minutes of the Eighty-First Annual Meeting as published in the June 1955 Journal were approved.

President Milton asked the First Vice President, Dr. Thomas C. Kenaston, to take the Chair.

Dr. Kenaston: "It is my honor and privilege to present to this group our President, Dr. John D. Milton, who will address us."

Dr. Milton delivered his presidential address. (The complete text may be found in this issue of The Journal on page 19.)

Dr. Milton resumed the Chair.

Dr. Milton: "At this time I would like to read a telegram of greetings from Dr. Thomas A. Price, President, Florida State Dental Association: 'Greetings and best wishes for a successful meeting'."

Dr. Milton: "I would like to recognize Dr. John R. Fowler, President of the American Academy of General Practice, from Barre, Massachusetts. I would like Dr. Fowler to come forward and speak to us for about three minutes."

Dr. Fowler: "Dr. Milton, I wish you had said ten seconds instead of three minutes.

"Mr. President, Members of the House of Delegates, Members of the Auxiliary, Distinguished Guests, Ladies and Gentlemen:

"It gives me a great deal of pleasure to bring to you the fraternal and warm greetings of the American Academy of General Practice, the second largest medical organization in these United States, a member of which is the distinguished President-Elect of the American Medical Association.

"Nine years ago when we established the American Academy of General Practice, it was for a definite purpose. Based on the philosophy that the general physician had let himself sink into a state of lethargy and had no voice to compete with other great specialty groups which have developed in this country, we felt that we owed it to the American people to bring to them the best possible medical care at reasonable cost. In order to carry out this philosophy, it became essential that we establish for ourselves a system of continued compulsory education. That is one fundamental principle on which we operate—we require of our members 150 hours of postgraduate work every three years. Failure to do so results in loss of membership.

"Another philosophy which we felt was necessary was to bring to the American people the kind of medical care we wanted to give them as it relates to hospital facilities. In order to give our patients the best care, we must be able to carry through, with the cooperation of others, all phases of their hospital care. At that time hospital facilities were rather hard for us to get. We decided, however, that no privileges should be asked except on the basis of training, experience and proven competence. I am glad to say at this point that more than 52 per cent of hospitals in the United States have established general practice departments. Those are the principles of the Academy. All other activities are based on the theory that we are primarily members of the A. M. A. and members of our state and county medical societies and that all problems pertaining to the general practice of medicine and all of its specialty branches is primarily the responsibility of the A. M. A., the state medical associations, and the component county medical units. Therefore, we as individual members of those units, work diligently through them for those things which are the responsibility of all organized medicine. All the political activity we support is carried on through those organizations.

We supported heartily the A. M. A. in its unanimous approval of the report of the Committee on Medical Practice which adopted to a large extent the basic philosophy of the American Academy of General Practice in that it was against any discrimination on the part of any hospital or group other than on the basis of individual competency. At the last interim session of the A.M.A.

unanimous approval was given to this report of the Medical Practices Committee which had been appointed by the A. M. A. and, in addition, implemented that by appointing a committee specifically instructed to work for the establishment of a general practice department in all medical schools and for the encouragement of the establishment of general practice departments in all hospitals. This has some teeth in that the members of the hospital commission were instructed that if a hospital discriminates against any physician because of his affiliation or non-affiliation with any organization or on any other basis than proven competence and that competence being judged on the local basis by the hospital staff, that that hospital could be penalized and possibly its accreditation questioned or removed. This, gentlemen, is the work of the A. M. A. It is the responsibility of every state medical association and I believe that it goes far to carry forward the basic ideal that we are working only for the best interest of the individual patient. It makes it possible for the service to have an over-all control of the treatment which that patient receives from the cradle to the grave.

"I appreciate this opportunity to speak to you and it is such a delight to be in Florida not only for the climate but particularly for the people whom I have met. Thank you very much."

Dr. Milton: "Dr. Fowler, we appreciate the words of wisdom and advice that you have given us."

"I would like to recognize our Woman's Auxiliary. Mrs. Lombardo, will you stand?"

The House applauded vigorously.

Dr. Milton: "We will now have a report from Dr. Homer L. Pearson Jr., Secretary of the State Board of Medical Examiners."

Report To: Florida Medical Association
From: Florida State Board of Medical Examiners

While the Florida Board of Medical Examiners is not a responsibility of the Florida Medical Association we felt that a report to you would be in order since the two were so closely related and interested in the same things. As far as I know such a report has not been made before, and since so many questions are put to the board by members of the association we would like to take this opportunity to give a brief narrative account of our activities.

The Florida Board of Medical Examiners is made up of ten medical doctors appointed by the governor for staggering terms of four years each. These terms are arranged so that a governor can appoint a complete new board during his four year administration. He has the right to appoint any medical doctor he desires: however, occasionally we have a governor who asks for recommendations from the Board of Governors of the Florida Medical Association—Mr. Collins is one of these. Doctors now serving on the board are: Morris B. Seltzer, President, Daytona Beach; E. B. Hardee, Vice-President, Vero Beach; Ralph B. Spires, DeFuniak Springs; Andrew G. Brown, Miami; A. H. Lisenby, Panama City; Sidney Stillman, Jacksonville; Frank D. Gray, Orlando; George S. Palmer, Tallahassee; Madison R. Pope, Plant City; and myself, Homer L. Pearson, Miami. Our assistant secretary is Mrs. Marjoriann Keebler of Miami.

We operate on a budget which is approved by the Legislature. The board members are paid $10.00 per day for each day spent attending board business, transportation to and from the place of meeting, and $7.50 per diem while away from home. The secretary receives $100.00 per month and the assistant secretary $250.00.

We meet semi-annually in June and November for the purpose of transacting board business and examining candidates for licensure. Other meetings can be held if necessary.

To qualify for examination one must meet these requirements:

(1) Be twenty-one (21) years of age.
(2) Be an American citizen.
(3) Be of good moral character.
(4) Possess a certificate of proficiency from the Florida Board of Basic Science Examiners.
(5) Be a graduate of an accredited medical school.
(6) Pay a fee of $50.00.
(7) File application thirty days prior to the examination date.

To be granted a license the candidate must make an over all average of 75 per cent on the ten subjects given.

License can be granted only by the board. They can also be revoked only by the board. The law is specific in causes for suspension or revocation; however, before such action can be taken we must grant legal hearings and have absolute proof of misconduct. The board has authority to discipline the holder of a license who has been heard and found guilty by the board of any of the following:

(1) Fraud in the practice of medicine, or fraud or deceit in his admission to the practice of medicine.
(2) Conviction of a felony in the courts of this or any other state, territory, or country. The conviction of any offense in another state, territory, or country, which if committed in this state would be deemed a felony shall be held to be a felony under this section without regard to its designation in such other state, territory, or country.
(3) Engaging in the practice of medicine under a false or assumed name, or the impersonation of another practitioner of a like, similar, or different name.
(4) Addiction to the habitual use of intoxicating liquors, narcotics or stimulations to such an extent as to incapacitate him from the performance of his professional obligations and duties.
(5) Untrue, fraudulent, misleading or deceptive advertising; advertising that he is able to treat or cure diseases by any secret method, procedure, treatment or medicine; or that he is able to cure a manifestly incurable disease.
(6) Obtaining a fee, or other things of value, on representation that a manifestly incurable disease can be permanently cured.
(7) Causing the publication or circulation of an advertisement of any medicine whereby the monthly periods of women can be regulated or the menses, if suspended can be reestablished.
(8) Causing the publication or circulation of fraudulent advertisement relative to any disease of the sexual organs.
(9) The procuring, aiding or abetting in procuring of criminal abortion.
(10) Is guilty of immoral or unprofessional conduct.

(11) Maintains a professional connection or association with any other person who continues to violate the provisions of this law, or the rules and regulations of the board duly made pursuant thereto, after ten days' notice in writing by the board.

(12) Has been adjudged insane by a court of competent jurisdiction (within or without this state). Where a person has been so adjudicated he shall be deemed disqualified to practice medicine in this state so long as such adjudication shall remain in full force and effect and the disabilities of such person have not been judicially restored; unless the board shall, after a full hearing, order otherwise.

When the board was originally formed it was a regulation that only graduates of Grade A schools would be accepted. After the war there were a number of graduates from unapproved schools who felt that if they were acceptable to the military services during the war they should at least be permitted to stand the examinations. After consulting with the American Medical Association the board altered its regulations to allow graduates of unapproved schools to qualify for examination by having two years of approved postgraduate training. Later the Medical Practice Act was amended to allow acceptance of graduates of unapproved schools provided their postgraduate training, was in the opinion of the board, enough to make their training equal to that of a graduate of an approved school. At this time the board began accepting these graduates who had had one year internship and two years residency in hospitals approved for such training by the Council on Medical Education and Hospitals of the American Medical Association.

It soon became apparent that we had been let in for a lot of grief and criticism. It is amazing how many such graduates there are who wish to come to Florida, who have so much sickness in the family which requires the Florida climate, who barely qualified under our ruling, and who had so many political friends in high places in this and other states. We realized that something must be done about it. So, the Legislature was asked to amend the Medical Practice Act again, and at the last session the paragraph allowing graduates of unapproved schools to be accepted was omitted and we now accept only graduates of the schools approved by the Council on Medical Education and Hospitals of the American Medical Association. This includes both domestic and foreign schools.

We do not grant temporary licenses even though the law permits it in cases of emergency. Such licenses cause only grief and confusion. When one is granted it is practically guaranteeing the doctor a permanent license when he stands the board. After all, how can ten men be so cruel to a fellow practitioner as to make him close up shop after he has bought a home, entered his children in school, leased an office for five years, and gotten his wife pregnant?

There are many hospitals, and at least two medical schools, that think we are hindering progress when we refuse to grant temporary licenses to radiologists, pathologists, anesthesiologists, and others, who they wish to head their various departments.

We have many instances of small towns which have found a doctor who will locate there, "if they will get him a license." These people behave as if they think we are trying to keep their community without medical service because we will not grant a temporary license to their doctor. Often the doctor they have been propositioned by cannot even qualify for our examinations. In the days when we "fell for" that kind of thing it was the usual procedure for the doctor to leave the community when he received his permanent license. Then the people were on our necks again! The result is that we do not issue temporary licenses.

We do not require a Florida license for those employed in state owned and operated mental institutions, tuberculosis hospitals, and prisons, but the doctor must be licensed in at least one other state. This exception is made because doctors with Florida licenses enter private practice and leave the hospitals without doctors.

There is no shortage of doctors in Florida. This may be contrary to what you have read in "Medical Economics" or what you have been told by the "do gooders." True, there are areas in the state which need doctors badly, and it is very difficult to convince the people in those areas that there is no shortage. It is difficult also to convince the mother of a sick child who is unable to get a doctor in the middle of the night that there is no shortage. We admit there is poor distribution but we deny there is a shortage.

The population of Florida is between 3,000,000 and 4,000,000 people. We now have 3,967 licensed medical doctors practicing in the state, and 2,186 medical doctors with Florida licenses who reside outside the state, making a total of 6,153 medical doctors licensed to practice in the state. In the last fifteen (15) years we have examined 5,283 candidates, 4,488 were granted licenses, and 795 failed. The mortality rate has been approximately 13 per cent.

In the last five (5) years Florida has shown the highest increase in medical doctor population in the nation with 49.8 per cent. The next highest is California with an increase of only 24.6 per cent.

We are screamed at by many because we do not reciprocate with any other licensing board. It would be much less work and grief if we did; however, if the increase is nearly 50 per cent with standards and restrictions high and the examinations hard what would it be if we opened the door wide? There would be a shortage of doctors in the rest of the United States!

We know there are many questions which come to your mind concerning the board. We hope you will feel free to question us at any time on such matters. We would like to tell you why we do this or why we don't do that.

Finally, let me assure you that we are also members of the Florida Medical Association, and that we are making every effort to maintain the highest standards for licensure in this state. It is very difficult to separate the chaff from the grain but we are using every means at hand and are making an honest effort to select the best doctors that can be had for Florida.

Respectfully submitted,
Homer L. Pearson, *Secretary-Treasurer*

Dr. Milton: "This year we helped to send a representative from the University of Miami Medical School to the meeting of the Student American Medical Association. I would like to have this delegate give a short report of his visit. This is Mr. Jack Eff, President of the Miami Student Medical Association."

Report on National Convention of The Student American Medical Association

The Sixth Annual Student AMA Convention was held in Chicago May 4 to 6, 1956. This report on the Convention has been prepared for the Florida Medical Association by Jack Eff, the delegate from the University of Miami. It was an honor and privilege to represent my University at this Convention and I should like to take this opportunity to thank the Florida Medical Association for making the amount of $300 available to the Miami Student Medical Association for the purpose of defraying my expenses and those of the alternate delegate, George Letchworth. This is greatly appreciated by both of us and our organization.

There were 61 of 71 member schools represented in the House of Delegates, the largest House ever assembled at an SAMA convention. The House of Delegates considered resolutions concerning medical education, graduate training, premedical counseling and others.

The House voted to have the Standing Committee on Medical Education prepare a sample curriculum evaluation questionnaire to be sent to all schools to aid in evaluating their curriculum on a local level and eventually to aid in a national curriculum evaluation. This Standing Committee was instructed by the House to continue in its gathering of statistics of chronic diseases in medical students, since in the future these data may be invaluable as a basis for the establishment of preventive measures and funds to alleviate the hardships incurred by these students. It was the unanimous opinion of the House that the Student American Medical Association should continue to support, in every way possible, the activities of Medical Education Week. This Medical Education Committee was also instructed to prepare positive suggestions for valuable programs in premedical counseling and in vocational guidance as related to medicine, in order that student organizations may begin active participation in this much-needed project.

The House voted to have the Standing Committee on Graduate Training investigate further the best methods for making internship evaluations available to students upon request. A resolution was passed to send a letter of commendation to all hospitals which have a good intern program as well as adequate facilities and stipends for interns.

It was decided that the Student American Medical Association would not join the International Federation of Medical Student Associations, but would continue to consider it, since no value can be gained by membership at this time.

A resolution to establish "Regionalization" of the Student American Medical Association was considered sound in purpose, but not in implementation, and therefore was referred to the Executive Council for further study.

Many other resolutions were considered and acted upon by the House of Delegates.

I was appointed to, and consequently served on, the Reference Committee on Medical Education.

A panel discussion of chapter problems was conducted by the Executive Council, the members of which spoke on problems such as dues, membership, programs, etc.

Another panel discussion was entitled, "Treatment from the Press," and members of the panel included such men as Gilbert Cant from Time Magazine; Arthur Snyder from Chicago Daily News; Robert Goldman from Parade Magazine; and others of prominence in this field. This was an interesting discussion of the problems arising in the relationship between the medical profession and those people responsible for reporting medicine to the people.

At the banquet, the Alpha Omega Alpha Lectureship was filled by Congressman and Dr. Walter Judd from Minnesota. He impressed all as being a sincere, dedicated person and he delivered a very stirring message on our responsibility to good government as future doctors.

Many organizations such as the American Medical Association, the Association of American Medical Colleges, American Medical Association Auxiliary, and American Medical Association Committee on Medical Education sent representatives who greeted the House on behalf of their respective associations.

The last order of business was the election of national officers for the coming year. They were as follows: President—Kent Guild from Northwestern University; Vice-President—Michael McQuillan from Georgetown University; Treasurer — Barry Manual from Boston Medical College and seven members to the Executive Council:

1. Anderson, Stig—University of Michigan
2. Baldus, William—Marquette
3. Baird, Robert—Jefferson Medical College
4. Eff, Jack—University of Miami
5. Rako, Robert—Cincinnati Medical College
6. Rosan, Robert—Albany Medical College
7. Younger, Carl—U.C.L.A.

Respectfully submitted,
Jack Eff, *Delegate*

Dr. Milton: "Jack, we wish to thank you for representing the University of Miami at the annual meeting of the Student American Medical Association. Since we have had your report and it was recommended in my address that there be a fund allotted for the expenses of sending representatives to the Student American Medical Association, I wish to refer that portion of my address to Reference Committee No. 3 for action."

President Milton called for the election of two delegates and two alternates to the House of Delegates of the American Medical Association, for two-year terms beginning January 1, 1957.

The Chair recognized Dr. Herbert L. Bryans of Escambia.

Dr. Bryans: "Mr. President, Members of the House, the Escambia County delegation considers it a privilege and a pleasure to nominate a man who has proven his ability. To enumerate all of his fine attainments would require considerable time. I am sure you are all acquainted with those attainments. Suffice it to say that the A.M.A. has recognized them by appointing him to three very important committees. I wish to nominate Dr. Reuben B. Chrisman Jr.

Dr. Ralph W. Jack: "Mr. President, Members of the House of Delegates; Escambia County is a long way from Dade County, but as Dr. Bryans has told you the deeds of Dr. Chrisman are well known throughout the nation in organized medicine. We would like to keep him in Dade where we need his many talents very much. However, we are happy to second his nomination for delegate and offer his services to the Florida Medical Association and the A.M.A."

Dr. Milton: "Are there any other nominations for the position of first delegate?"

Dr. H. Phillip Hampton moved that nominations be closed and that the secretary be instructed to cast the ballot for Dr. Chrisman.

Motion seconded and carried.

The Chair recognized Dr. Homer L. Pearson Jr. of Dade.

Dr. Pearson: "For alternate to Dr. Chrisman, I would like to nominate Dr. Frank D. Gray to succeed himself."

Seconded by Dr. Chas. J. Collins.

It was moved, seconded and carried that nominations be closed.

The Chair asked for a voice vote for Dr. Gray.

Dr. Milton: "The ayes have it. Dr. Gray is elected."

The Chair recognized Dr. Clyde O. Anderson of Pinellas.

Dr. Anderson: "Mr. President, House of Delegates: It is an extreme pleasure for me to present today the name of an old friend of mine for more than 30 years. We are somewhat separated from West Florida, but the gentleman I have in mind has made us a fine representative as a delegate. I would like to place before you the name of Francis T. Holland of Tallahassee."

Dr. George W. Morse: "Mr. President, Members of the House of Delegates: The Escambia County Delegation is proud to second the nomination of Dr. Holland. He has been a credit to our state and has done an excellent job with Dr. Chrisman in representing the Florida Medical Association."

The Chair recognized Dr. Leo M. Wachtel Jr. of Duval.

Dr. Wachtel: "I wish to present in nomination for the position of second delegate to the A. M. A. a man who is chairman of this Association's Committee on Medical Education and Hospitals, past president of the Florida Chapter, American Academy of General Practice, regularly attends the A.M.A. meetings, and in addition is a member of that great group in the Florida Medical Association, that group which represents the greatest number of our members—a general practitioner, Dr. Walter E. Murphree of Alachua County and Gainesville."

Dr. Cecil M. Peek: "On behalf of the Palm Beach County Delegation, I have the honor to second the nomination of Dr. Murphree."

Dr. Jere W. Annis: "On behalf of the Polk County Delegation, I would like to second the nomination of Dr. Holland, and remind you, as good a friend as I am of Dr. Murphree, that we are sending a representative of the State Association and not of any group interest. I would certainly hate to see that feeling creep into such an election. We must also remember that the man who goes up there can attain stature only by years of service. That has been proven by Dr. Pearson's, Dr. Orr's and Dr. Chrisman's work in the past. Francis Holland has done well, a good job, and I believe can do a better job for us. Again, he is the representative of all of us, and not of any one group."

Dr. Walter W. Sackett Jr.: "In behalf of Walter Murphree, I would like to say that we are not attempting to inject any specialty versus general practice politics into this election, but we would like to see, from this great rural state, one general practitioner as a delegate."

Dr. Ralph Herz: "I move that nominations be closed."

Motion seconded and carried.

The Chair ruled that a secret ballot was in order and appointed as tellers Drs. Robert E. Zellner, Ralph M. Overstreet Jr., and S. Carnes Harvard.

Dr. Milton: "Just to avoid any criticism, I would like to call your attention to the fact that Dr. Pearson made a motion. He is not seated as a delegate, but according to the By-Laws, Chapter VII, Sec. 21, any past president of the Association does have the privilege of the floor and shall be recognized by the Chair."

The tellers reported the result of the secret ballot; Dr. Holland 96 votes, Dr. Murphree 43 votes. The Secretary announced that Dr. Francis T. Holland had been elected as delegate to the American Medical Association.

The Chair called for nominations for an alternate delegate to the A.M.A.

Dr. Annis: "I nominate Dr. Walter E. Murphree."

Seconded by Dr. Sias.

On motion by Dr. J. Raymond Graves, nominations were closed.

Seconded and carried.

The Chair called for a voice vote and announced that Dr. Murphree was elected.

Dr. Milton read the personnel of the four reference committees as follows:

1. HEALTH AND EDUCATION

Civic Room

Warren W. Quillian, Chairman
Jere W. Annis
Donald F. Marion
John E. Maines Jr.
A. Judson Graves

2. PUBLIC POLICY

Boom Boom Room

Francis H. Langley, Chairman
Chas. J. Collins
S. Carnes Harvard
Walter E. Murphree
Edward Jelks

3. FINANCE AND ADMINISTRATION

North Card Room

Louis M. Orr, Chairman
Samuel M. Day
Russell B. Carson
Donald W. Smith
George W. Morse

4. LEGISLATION

South Card Room

Edward R. Annis, Chairman
H. Phillip Hampton
Francis T. Holland
Joseph J. Lowenthal
V. Marklin Johnson

The following committee reports and resolutions were referred as published in the Handbook, together with supplemental reports and additional resolutions as presented:

(To Reference Committee No. 1)

Scientific Work, Donald F. Marion

Medical Postgraduate Course, Turner Z. Cason

Cancer Control, Ashbel C. Williams

Venereal Disease Control, A. Buist Litterer

Tuberculosis and Public Health, Lawrence C. Manni

Maternal Welfare, E. Frank McCall

Child Health, Warren W. Quillian*

Blood, Louis E. Pohlman

Mental Health, Sullivan G. Bedell*

Resolution: Recommendation to Blue Cross Relating to Visiting Nurse Association — Sarasota County Medical Society

Resolution: Fluoridation Public Water Supplies — Orange County Medical Society

Resolution: Blood Donor Program — Dade County Medical Association

*Supplemental report presented and referred.

(To Reference Committee No. 2)

Conservation of Vision, Hugh E. Parsons

Medical Education and Hospitals, Jack Q. Cleveland

Medical Economics, Robert E. Zellner

State Controlled Medical Institutions, Edward H. Williams

Representatives to Industrial Council, John H. Mitchell

Grievance, Herbert E. White

Nursing, Jere W. Annis*

Resolution: Review Working Agreement with National Foundation of Infantile Paralysis—Sarasota County Medical Society

Resolution: Studies on Degrees of Indigency—Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society

Resolution: Advertising on Prescription Blanks—Pinellas County Medical Society

*Supplemental report presented and referred.

(To Reference Committee No. 3)

Board of Governors, John D. Milton*

Necrology, Walter W. Sackett Jr.*

Advisory to Woman's Auxiliary, Wiley M. Sams

Councilor Districts and Council, Ralph W. Jack*

Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell

Emergency Medical Service, Rowland E. Wood

Resolution: Expenses of Association Officials—Orange County Medical Society

*Supplemental report presented and referred.

(To Reference Committee No. 4)

Legislation and Public Policy, H. Phillip Hampton

Resolution: Study of Driver Licensing Law — Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society

The Chair recognized Dr. Robert E. Zellner, Chairman, Committee on Medical Economics.

Dr. Zellner: "I would like to call to your attention page 27 of your Handbook, Recommendation V, which was passed by this body last year. This recommends that insurance committees be established in each county society and states that the societies will be contacted. They have been contacted and asked if an insurance committee has been established. To date only eight replies have been received. That is not a very good response and I urge the members of this House to return to their county societies and ask that such committees be organized.

Yesterday the Medical Economics Committee met with representatives of the insurance industry and we offered them the services of our insurance committees in the evaluation of claims for malpractice which are made against you and your fellow members. Unless these committees are organized and functioning, these people have nowhere to go. These men will be calling on you, so please don't wait until your house is on fire before you organize a fire department. This is one thing that the Insurance Commissioner has insisted upon—that we put our house in order to keep our rates low.

The insurance industry, up to the present time, has not seen fit to underwrite a group malpractice plan for the State of Florida. They are writing them in other states—it seems they will write them anywhere but in Florida. We will continue to try to get such a plan. That makes it even more important that we appoint these insurance committees as evidence of our faith and good will."

Dr. Milton: "Dr. Edward H. Williams, Chairman of the Committee on State Controlled Medical Institutions, has written a report which is somewhat long and there is a question as to whether you want to hear it read?"

Dr. Maurice M. Greenfield: "I move that the

report be filed with the Reference Committee for study."

Seconded by Dr. W. Dean Steward.

Motion carried.

The Chair called for resolutions from the floor.

Dr. Burns A. Dobbins, of Broward, presented five resolutions as follows: a resolution on expenses of association officers which was referred to Reference Committee No. 3; a resolution on State Board of Medical Examiners to Committee No. 2; a resolution inviting the Association to hold its 1957 meeting in Hollywood, to Committee No. 3; a resolution on time of the Annual Meeting, to Committee No. 3; a resolution on standardization of insurance forms, to Committee No. 3.

Dr. Russell B. Carson presented a resolution from the Board of Directors of Blue Shield, which was referred to Reference Committee No. 3.

Dr. Herbert L. Bryans, of Escambia, presented a resolution on Fluoridation of Water, which was referred to Reference Committee No. 1.

Dr. Franklin J. Evans, of Dade, presented a resolution on advertising by members of the Healing Arts, which was referred to Committee No. 4.

Dr. Charles R. Sias, of Orange, presented a resolution on Medical Practices, which was referred to Reference Committee No. 2.

Dr. Walter E. Murphree, of Alachua, presented a resolution on the relationship between medical school faculties and physicians of the community, which was referred to Reference Committee No. 2.

Dr. Millard P. Quillian, of Manatee, presented a resolution on Policy of State Hospitals, which was referred to Committee No. 2.

There being no further business, the House of Delegates recessed at 12:15 p.m. to reconvene at 10:30 a.m. on Wednesday, May 16, 1956.

Second House of Delegates

The House of Delegates reconvened at 10:30 a.m. on Wednesday, May 16, 1956, in the La Ronde Room of the Hotel Fontainebleau, Miami Beach, President John D. Milton in the Chair.

Dr. Ralph W. Jack, Chairman of the Credentials Committee, was recognized and reported that a quorum was present. (Subsequent report of the Credentials Committee showed 140 delegates registered.)

Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, John E. Maines Jr.

BAY—William C. Roberts

BREVARD—Theodore J. Kaminski, Laurent L. LaRoche

BROWARD—Julius F. Boettner, Russell B. Carson, Burns A. Dobbins Jr., Donald H. Gahagen, John H. Mickley, Richard A. Mills

COLUMBIA—Laurie J. Arnold Jr.

DADE—Edward R. Annis, Harry E. Beller, Turner E. Cato, Reuben B. Chrisman Jr., Jack Q. Cleveland, Francis N. Cooke, Vincent P. Corso, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Richard M. Fleming, George Gittelson, J. Raymond Graves, Maurice M. Greenfield, R. Spencer Howell, James J. Hutson, Ralph W. Jack, Walter C. Jones, David Kirsh, Alfred G. Levin, Donald F. Marion, Frazier J. Payton, Frederick P. Poppe, Warren W. Quillian, Hunter B. Rogers, Walter W. Sackett Jr., T. D. Sandberg, Ralph S. Sappenfield, Oden A. Schaeffer, Donald W. Smith, Joseph S. Stewart, William M. Straight, Oliver P. Winslow Jr., Corren P. Youmans

DeSOTO-HARDEE-HIGHLANDS-GLADES—*(Absent—James G. Smith)*

DUVAL—James L. Borland, Frederick H. Bowen, Hugh A. Carithers, J. K. David Jr., A. Judson Graves, Karl B. Hanson, Arthur L. Hardie Jr., Gordon H. Ira, F. Gordon King, Raymond H. King, Joseph J. Lowenthal, Charles F. McCrory, Kenneth A. Morris, Sidney Stillman, Leo M. Wachtel Jr.

ESCAMBIA—Herbert L. Bryans, Alpheus T. Kennedy, George W. Morse, Walter C. Payne Sr., Gretchen V. Squires

FRANKLIN-GULF—Joseph P. Hendrix

HILLSBOROUGH—H. Phillip Hampton, Eugene B. Maxwell, David R. Murphey Jr., Wade C. Myers Jr., Julien C. Pate Jr., James N. Patterson, Madison R. Pope, William M. Rowlett, Edward F. Shaver, *(Absent—Robert W. Withers)*

INDIAN RIVER—William L. Fitts 3rd.

JACKSON-CALHOUN—James T. Cook Jr.

LAKE—*(Absent—Sanford C. Colley)*

LEE - CHARLOTTE - COLLIER - HENDRY — Earl S. Davis, William H. Grace

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON—Francis T. Holland, George H. Massey, Robert H. Mickler

MADISON—*(Absent—Candler K. Hayes)*

MANATEE—Millard P. Quillian

MARION—Henry L. Harrell

MONROE—Ralph Herz

NASSAU—Benjamin F. Dickens

ORANGE—Frank C. Bone, Chas. J. Collins, Carl S. McLemore, Louis M. Orr, Frank J. Pyle, Charles R. Sias, W. Dean Steward, Robert L. Tolle, Robert E. Zellner

PALM BEACH—Edwin W. Brown, C. Jennings Derrick, V. Marklin Johnson, Walter R. Newbern, Ralph M. Overstreet Jr., Cecil M. Peek, Raymond S. Roy

PASCO-HERNANDO-CITRUS—S. Carnes Harvard

PINELLAS—Clyde O. Anderson, Curtis W. Bowman, Elmer B. Campbell Sr., Harry R. Cushman, N. Worth Gable, Percy H. Guinand, Daniel F. H. Murphey, John P. Rowell, James E. Thompson, Walter H. Winchester, Rowland E. Wood

POLK—Jere W. Annis, James R. Boulware Jr., Marion W. Hester, James T. Shelden, Edgar Watson

PUTNAM—*(Absent—Lawrence G. Hebel)*

ST. JOHNS—Reddin Britt

ST. LUCIE-OKEECHOBEE-MARTIN—Richard F. Sinnott

SARASOTA—John M. Butcher, Hugh G. Reaves, Melvin M. Simmons

SEMINOLE—Terry Bird

SUWANNEE—Edward G. Haskell Jr.

TAYLOR—*(Absent—Charles R. Wiley)*

VOLUSIA—C. Robert DeArmas, William R. Hutchinson, Howard W. Reed, *(Absent—Theodore F. Hahn Jr.)*
WALTON-OKALOOSA—Frederic E. Caldwell
WASHINGTON-HOLMES—*(Absent—Martin L. Lane)*
STATE OFFICERS—John D. Milton, Francis H. Langley, Thomas C. Kenaston, Sidney G. Kennedy Jr., Walter E. Murphree, Samuel M. Day, Shaler Richardson

Report of Reference Committee No. 1

The Chair called for the report of Dr. Warren W. Quillian, Chairman of Reference Committee No. 1, Health and Education. This committee was composed of Drs. Jere W. Annis, Donald F. Marion, John E. Maines Jr. and A. Judson Graves.

Dr. Quillian: "The Committee on Health and Education met yesterday afternoon in the Civic Room with all members present.

"The Committee was very pleased to have a good many members of the Association present to assist us in our deliberations and to give us background information so that we might make intelligent recommendations to the House of Delegates.

"The resolution from the Sarasota County Medical Society on recommendation to Blue Cross relating to Visiting Nurse Association, is approved as published in the Handbook.

"I move the resolution be adopted."

Seconded by Dr. Jere W. Annis.

Motion carried.

Resolution

Recommendation to Blue Cross Relating to Visiting Nurse Association

BE IT RESOLVED that the Sarasota County Medical Society go on record as recommending that Blue Cross of Florida, Inc., investigate the possibility of covering post-hospitalization follow-up of post-operative and medical patients by the Visiting Nurse Association, in the interest of earlier discharge of these patients from the hospital, and the more efficient use of the available beds in the hospital.

Respectfully submitted,
Karl R. Rolls, Secretary
Sarasota County Medical Society

Dr. Quillian: "The resolution on Fluoridation of Public Water Supplies presented by the Orange County Medical Society, is approved with the following amendments: In paragraph 4. lines 5 and 6, page 22 of the Handbook, change 'to bring the total fluoride concentration to one part per million' to read, 'to bring the total fluoride to such concentration as is approved by the Florida State Board of Health.'

"It was pointed out that in the State of Florida there are varying amounts of fluoride in the water and since it is a function of the State Board of Health to approve water supplies, it would be appropriate to make this change in the resolution.

"I move the resolution be adopted as amended."

Seconded by Dr. Ralph Herz.

Motion carried.

Resolution

Fluoridation Public Water Supplies

WHEREAS, the addition of fluoride in proper concentration to community water supplies deficient in that ion has been shown by extensive research to be an effective method of reducing the incidence of dental caries in those who drink the water from birth, and

WHEREAS, many careful studies have failed to reveal the existence of any physical damage or illness due to the ingestion of properly fluoridated water, and

WHEREAS, the American Medical Association and many State and County Medical Associations have gone on record as approving this public health measure,

NOW THEREFORE BE IT RESOLVED, that the Florida Medical Association declares itself to be wholeheartedly in favor of the addition of a sufficient amount of a suitable fluoride to community water supplies to bring the total fluoride to such concentration as is approved by the Florida State Board of Health, and recommends that local medical societies likewise approve this measure and work actively to bring about its adoption in Florida cities and communities, and

BE IT FURTHER RESOLVED, that copies of this resolution be sent to the State Board of Health and to the secretary of each county medical society in the state of Florida.

Respectfully submitted,
W. Ansell Derrick, *Secretary*
Orange County Medical Society

Dr. Quillian: "The resolution on Fluoridation of Public Water Supplies presented by the Escambia County Medical Society, is approved with the following addition at the end of the last sentence —'an amount specified by the Florida State Board of Health.'

"I move the resolution be adopted as amended."

Seconded by Dr. Herz.

Motion carried.

Resolution

Fluoridation of Public Water Supplies

WHEREAS, the Escambia County Medical Society has officially endorsed the fluoridation of public water supplies; and

WHEREAS, the local Dental Society has officially endorsed the fluoridation of public water supplies; and

WHEREAS, the Florida State Board of Health, after extensive study of the subject and after a public hearing on August 20, 1955 at which time both the opponents and proponents presented their views, has officially gone on record to the effect that the fluoridation of public water supplies with a safeguards required by that Agency will prevent a substantial percentage of dental caries in children; and that it is harmless to the health of any group of the population; and

WHEREAS, the following national organizations along with many others have endorsed the principle of the fluoridation of public water supplies:

American Medical Association
American Dental Association
American Public Health Association
American Pharmaceutical Association
American Nurses Association

American Association for the Advancement of Science
National Research Council
National Institute of Municipal Law Officers
American Water Works Association
American Hospital Association
U. S. Public Health Service
National Congress of Parents and Teachers

NOW THEREFORE BE IT RESOLVED, That the Escambia County Medical Society urge the Florida Medical Association to officially approve the principle of fluoridation of public water supplies in those areas where natural fluorides are not present in an amount specified by the Florida State Board of Health.

Respectfully submitted,
Pascal G. Batson Jr., *Secretary*
Escambia County Medical Society

Dr. Quillian: "The resolution with reference to the Blood Donor Program, presented by the Dade County Medical Association, is approved with the following amendment: In the last paragraph, Part 2, line 3, change 'the American Red Cross,' to read, 'The Joint Council on Blood.'

"Dr. Lloyd R. Newhouser, Director of the John Elliott Blood Bank of Dade County, made appropriate comments in which he endorsed the sentiments expressed in the resolution.

"It is recommended that this resolution, if adopted by the Association, be referred to the proposed Committee on Blood or to such authority as is deemed wise by the Board of Governors, for appropriate action.

"I move the resolution be adopted as amended."

Seconded by Dr. V. Marklin Johnson.

Motion carried.

Resolution
Blood Donor Program

WHEREAS, the use of blood transfusion therapy has become one of the important modern advances in medical and surgical care that is used with a definite degree of frequency and should be readily available for all, and

WHEREAS, the members of the Dade County Medical Association and their patients have had available to them ample supplies of blood for transfusion through the use of a long-established program which uses voluntary rather than professional donors, and

WHEREAS, the program which has operated so successfully here has as its basic philosophy the concept that the responsibility for the replacement of blood should be lodged with the patient, his family and his friends, and

WHEREAS, the members of the Dade County Medical Association have learned that there is a growing tendency among insurance companies writing policies covering hospitalization, medical and surgical care, to include in these policies blood transfusion benefits which can include payments for the use of professional donors, and

WHEREAS, exponents of professional blood donor programs admit that they could not possibly provide all of the blood needed daily in the routine medical and surgical care of the civilian population of the country alone, and

WHEREAS, the widespread use of professional rather than voluntary donor program will in addition cause the average total cost for transfusion to be substantially increased, and

WHEREAS, the widespread adoption of a program using professional donors will tend to destroy the success of a voluntary donor program so well-established here and in most areas of the country, and

WHEREAS, the continuance of such an insurance program that interferes with the success of a voluntary blood donor program will seriously affect the National Defense program since such must require large stockpiles of dried plasma, plasma and blood for use in the event of atomic attack which can only be obtained by a nationwide continued use of a voluntary blood donor program, and

WHEREAS, such a program will also seriously interfere with the successful operation of a military blood procurement program if such should again be needed, and

WHEREAS, any concept that tends to destroy the success of a voluntary donor program that has been established as the result of many years of public education is in general a detriment to public welfare, and

WHEREAS, the members of the Dade County Medical Association view with alarm the spreading of such a concept through the inclusion by many insurance companies of benefits which provide for payment to professional donors for the replacement of blood,

NOW THEREFORE BE IT RESOLVED, that the members of the Dade County Medical Association assembled at their regular monthly meeting on Tuesday evening, February 7, 1956, declare themselves to be firmly in favor of a blood donor program which uses voluntary rather than professional donors, and that we further declare that a copy of this resolution be spread on the minutes of this association and be presented to the House of Delegates of the Florida Medical Association at its meeting in Miami Beach in May, 1956 with the recommendation that it be adopted by the Florida Medical Association, and with the further recommendation that this problem be presented to the proper authorities of the American Medical Association and, if advisable, to the House of Delegates of the American Medical Association at its meeting in June, 1956 with the suggestions that:

1. The American Medical Association take all steps necessary to discourage the continuance of such an insurance program and to encourage the continuation of the public voluntary blood donor program.
2. That they consult with the large national insurance carriers and their group organizations, the Joint Council on Blood, the AFL-CIO and other labor authorities, and the Department of National Defense and other appropriate state and federal government agencies to see what united action should be taken to stop this spreading insurance program that will produce such a serious detrimental effect upon the defense program for the nation and upon the successful use in most areas of the country of an important accepted adjunct in medical and surgical care and consequently upon the general public welfare.

Respectfully submitted,
Vincent P. Corso, *Secretary*
Dade County Medical Association

Dr. Quillian: "The report of the Committee on Scientific Work, as presented by Dr. Donald F. Marion, Chairman, is approved as published in the Handbook.

"The Committee has noted the excellent quality of the presentations on well diversified subjects and feels that attendance by registrants at the annual meeting has been fair under the circumstances. Noting the increased interest in

scientific exhibits, we urge suitable advantageous display of these exhibits, the presentation of which involves so much time, effort and expense on the part of our members. The large number of members who volunteered for presentation of a subject at our present meeting indicates a most encouraging increased cross section of general interest.

"I move the report be adopted."

Seconded by Dr. Earl S. Davis.

Motion carried.

Report of Committee on Scientific Work

Donald F. Marion, *Chairman*

The Scientific Work Committee met in Jacksonville on Nov. 20, 1955, to select a program for the Eighty-Second Annual Meeting. The Association should be proud to learn of the excellence of the large number of papers which were offered by Florida physicians and surgeons. The task of the committee was a difficult one because no single paper could be rejected because of its failure to measure up to high standards of accurate scientific reporting. Selection was based entirely upon the desire to provide the membership with a balanced and varied program, and in this respect the committee was satisfied. Regret was occasioned only by the limitations of time which prevented inclusion of all that was offered to us.

Papers were submitted by physicians outside of Florida, some of which might have added to the variety of the program but none appeared to offer information of greater value than that which came to us from within our own boundaries. Accordingly, the committee believes and recommends that scientific papers selected for the annual meeting should be chosen from those submitted by Florida doctors whenever their number and excellence equals that which prevails at the present time.

There appears to be an increasing interest in scientific exhibits, and many excellent ones were offered this year. Space limitations plague the committee and the Association's headquarters staff every year, but this year the problem has been especially acute. In all future planning for meeting places this growing interest and desire to exhibit should be borne in mind. The effort and expense involved in the preparation of a good teaching exhibit is considerable, and we owe each exhibitor the best physical facilities obtainable.

Sincere thanks for effective work is extended to Arthur Butt, Richard Cumming, Richard Beeser Jr. and Scottie Wilson, members of the Scientific Work Committee, and to Mr. Gibson and Mr. Parham for their superb staff work and invaluable assistance.

Respectfully submitted,

Donald F. Marion, *Chairman*

Dr. Quillian: "The report of the Committee on Medical Postgraduate Course, presented by Dr. Turner Z. Cason, Chairman, is approved as published in the Handbook.

"During discussion of the content of the report in which Dr. Cason participated, it was urged that all interested groups within the state of Florida, which are planning formal graduate education courses, submit their proposed programs of such activity at a reasonably advanced date to his committee for the purpose of coordination and integration of these activities throughout the state.

"I move the report be adopted."

Seconded by Dr. Herbert L. Bryans.

Motion carried.

Report of Committee on Medical Postgraduate Course

Turner Z. Cason, *Chairman*

The Medical Postgraduate Course Committee held two meetings during the year 1955. Both meetings were held at the George Washington Hotel in Jacksonville, the first on June 22 and the second, November 20.

At the June meeting the courses sponsored during the year 1954 were reviewed. The committee discussed at length its relationship to the newly established College of Medicine of the University of Florida and the probable future position and needs for this committee as related to graduate medical education in the state of Florida. The Director, Dr. George T. Harrell, Dean of the College of Medicine, University of Florida, requested that the committee continue its advice and direction through 1956. He further stated that after the appointment of a physician to the chair of graduate medicine had been made it was his desire that the Medical Postgraduate Course Committee continue in an advisory capacity to this department. The Department of Medicine of the Graduate School of the University would automatically be discontinued. The committee unanimously expressed its willingness to continue in this capacity or to serve in any way it might be called on. It was further the wishes of those present at this meeting that the committee offer its services in an advisory capacity to the Dean of the School of Medicine of the University of Miami. The committee chairman was requested to write Dean Homer F. Marsh, which he did. Dean Marsh replied to this letter stating that at present the University of Miami School of Medicine was not in a position to initiate graduate medical education.

The committee again discussed the question of keeping a record of dates for all graduate education and medical meetings at the headquarters of the Florida Medical Association and of urging any group who anticipates presenting any type of graduate medical education or having a medical meeting requiring statewide attendance to consult this department before arranging a date.

The committee further cooperated with the pediatricians of the state in presenting a one day graduate course in Jacksonville. This course stressed the neurological phases of pediatrics.

The question of presenting graduate medical education so that it would be legally deductible from income tax was discussed from every angle. It was brought out that no deductions could be made unless the course was presented in cooperation with an organized medical group. It was recommended that an effort be made to establish such an organization in connection with presenting graduate medical education whenever possible. The Florida Clinical Diabetes Association was pointed out as an example of a method of arranging special courses where the expenses of attendance can be legally deducted by the physicians in attendance. At the request of the committee the chairman will present a proposed plan for reorganizing the short course to the referral committee at the annual meeting of the Association in May.

The following courses were held during the year 1955:

Seminar on Cardiovascular Diseases, February 17-18, Duval Medical Center, Jacksonville, with 97 in attendance.

Seminar on Psychiatry, June 16-18, Hotel George Washington, Jacksonville, with 44 in attendance.

Twenty-Third Annual Graduate Short Course, June 20-24, Hotel George Washington, Jacksonville, with 152 physicians attending.

Seminar on Diabetes, October 20-21, Hotel Princess Issena, Daytona Beach, with 47 attending.

Neuro-Pediatric Seminar, October 30, Baptist Memorial Hospital, Jacksonville, with 37 in attendance.

Tenth Annual Midwinter Seminar on Ophthalmology and Otolaryngology, January 16-21, 1956, Miami Beach, with 300 attending.

Respectfully submitted,
Turner Z. Cason, *Chairman*

Dr. Quillian: "The report of the Committee on Cancer Control presented by Dr. Ashbel C. Williams, Chairman, is approved as published in the Handbook.

"I move the report be adopted."

Seconded by Dr. George W. Morse.

Motion carried.

Report of Committee on Cancer Control

Ashbel C. Williams, *Chairman*

A joint meeting of the Cancer Control Committee of the Florida Medical Association and the Florida Cancer Council was held in Jacksonville, January 15, 1956.

It was unanimously voted that the Southeastern States Cancer Seminar should be held in 1956 and that the host should be the Duval County Medical Society. The meeting has accordingly been offered the Duval County Medical Society and, if accepted, will take place in the fall of 1956 in Jacksonville. (It is the custom to stage this meeting every two years, rotating it among the larger cities in Florida.)

The 19 tumor clinics in Florida formally started their Cancer Registries January 1, 1956. After considerable deliberation, forms for this purpose were selected. These registry forms, along with the accessories necessary to operate the registries, have been shipped to all tumor clinics in the state. This initial equipment was provided by the American Cancer Society and distributed by the Florida State Board of Health.

A committee of the Florida Society of Pathologists has prepared a pamphlet on exfoliative cytology at the request of the Florida Cancer Council. This pamphlet will be distributed to all physicians in Florida later this year. It states briefly the technics of obtaining and preparing the various cytological specimens in common use and will list the pathologists in Florida who are ready to offer cytological diagnosis.

Your cancer committee will foster the proper use of exfoliative cytology in every possible manner so that its benefits may be extended to the greatest number of patients in Florida.

Respectfully submitted,
Ashbel C. Williams, *Chairman*

Dr. Quillian: "The report of the Committee on Tuberculosis and Public Health, presented by Dr. Lawrence C. Manni, Chairman, is approved with the following recommendations: That the project, 'The Shared Dietitian,' as presented by the Florida Dietetic Association, be further studied by the members of the Committee on Tuberculosis and Public Health, and their findings submitted to the Board of Governors of the Florida Medical Association for appropriate action.

"I move the report be adopted."

Seconded by Dr. Frederick H. Bowen.

Motion carried.

Report of Committee on Tuberculosis and Public Health

Lawrence C. Manni, *Chairman*

The Committee on Tuberculosis and Public Health had no meetings as there were no major problems presented which would require calling the Committee together. The following matters were considered by correspondence:

The matter of fluoridation of public water supplies was presented to the Committee for consideration and the majority of members were in favor of fluoridation and recommend its endorsement to the House of Delegates.

The project (The Shared Dietitian) was presented for consideration by the Florida Dietetic Association. It was felt by members of the Committee that this was a project worthy of consideration and should be investigated further for endorsement by the Florida Medical Association.

Respectfully submitted,
Lawrence C. Manni, *Chairman*

Dr. Quillian: "The report of the Committee on Venereal Disease Control, presented by Dr. A. Buist Litterer, Chairman, is approved as published in the Handbook.

"I move the report be adopted."

Seconded by Dr. Franklin J. Evans.

Motion carried.

Report of Committee on Venereal Disease Control

A. Buist Litterer, *Chairman*

The activity during the year 1955 is an outstanding example of what can be accomplished through the fine cooperative efforts of our private physicians and public health workers in the field of venereal disease control.

Statistically, we show a decrease of 19.6 per cent in the incidence of syphilis in the state for 1955 over 1954. Even more encouraging is the fact that there was a reduction of 12 per cent in primary and secondary syphilis and a reduction of 25.6 per cent in early latent syphilis. The selective blood testing surveys in Escambia, Polk and Seminole counties on 17,673 persons resulted in a positivity rate of 8.9 per cent.

The follow-up of contacts of infectious cases reported by the private physicians has increased by 58.9 per cent over 1954. The use of the T.P.I. (Treponema Pallidum Immobilization) test in diagnostic problem cases was used in 115 cases in 1955 compared to only 17 in 1954.

There was a slight increase in gonorrhea during the past year with 12,145 cases reported compared to 11,841 cases in 1954.

Chanroid, granuloma inguinale and lymphopathia venereum remained at about the same level.

Although great strides have been made in the control of venereal diseases, we still have much to accomplish. With the syphilis rate of 151.4 per hundred thousand population, a gonorrhea rate of 331.9 per hundred thousand population and a blood test survey positivity rate of 9 per cent, we cannot afford to stand idly by. We must intensify our case finding program through contact follow-up and blood test surveys and stimulate more interest in the V.D. problem through education. With these control measures and the newer types of therapy, the medical profession has one of the greatest opportunities to achieve control over these diseases.

Respectfully submitted,
A. Buist Litterer, *Chairman*

Dr. Quillian: "The report of the Committee on Maternal Welfare, presented by Dr. E. Frank McCall, Chairman, is approved with attached written statement as a supplement to the report.

"Dr. McCall was present at the meeting of our Reference Committee and made these comments as a supplement to his formal report: 'The Maternal Welfare Committee at its last meeting thought it might be helpful if we could publish each month in The Journal of the Florida Medical Association some timely comments in the field of obstetrics. This project was discussed with Mr. Ernest Gibson, Managing Director, and he agreed that space in The Journal could be provided. The project has been discussed with Dr. Fred Adair, formerly Chief of Obstetrics and Gynecology, University of Chicago, now retired and living at Maitland, Florida, and he has tentatively agreed to edit this page.'

"I move the report be adopted."

Seconded by Dr. Jere W. Annis.

Motion carried.

Report of Committee on Maternal Welfare

E. Frank McCall, *Chairman*

We have formed no new Maternal Welfare Committees in the state this year, but those already formed are doing an excellent job of reviewing the maternal deaths in their communities.

The Maternal Welfare Committee sponsored by the State Boards of Health of Florida, Georgia, and South Carolina, held an Obstetric and Pediatric Seminar at Daytona Beach September 12, 13, and 14. This meeting is showing a progressive yearly increase in attendance. Total registration was 305. The faculty for this meeting was as follows:

Dr. Samuel M. Wishik, University of Pittsburgh;
Dr. John Parks, The George Washington Univ. of Medicine;
Dr. William J. Dieckmann, The Chicago Lying-In Hospital;
Dr. Carl P. Huber, Indiana University Medical Center;
Dr. Charles E. Flowers, Jr., University of North Carolina;
Dr. W. Norman Thornton, University of Virginia;
Dr. Robert Lawson, University of Miami;
Miss Hazel Corbin, R. N., Maternity Center Association, N. Y.;
Dr. John D. Milton, University of Miami;
Dr. Fred Adair, Maitland, Florida;
Dr. James H. Ferguson, University of Miami.

Plans are now in progress to hold his meeting in Daytona Beach in 1956.

We are very pleased to report only 45 maternal deaths in Florida in 1955, with a total delivery of 81,034 births. This gives us a maternal mortality of 5.5 per 10,000, which is even lower than the 1954 record, and is lower than the national average. Florida should rank among the top three or four states in the nation.

Again, we are deeply grateful for all the help we have had from our sponsors in promoting this meeting. I would especially like to express our appreciation to the State Board of Health for making our Obstetric Seminar possible. They have always been most helpful in any worthwhile venture.

We would like to thank our President, Dr. John Milton, for his cooperation during the entire year as well as for his very excellent presentation and participation at the meeting in Daytona Beach in September.

Respectfully submitted,
E. Frank McCall, *Chairman*

Dr. Quillian: "The report of the Committee on Child Health, presented by Warren W. Quillian, Chairman, is approved as written in the Handbook. The Supplemental report in the form of a resolution concerning the increased incidence of poisoning in the state of Florida and the establishment of poisoning control centers to combat this situation is approved, as read to the House of Delegates yesterday.

"I move the resolution be adopted as a supplemental report and that the report be adopted as supplemented."

Seconded by Dr. James R. Boulware Jr.

Motion carried.

Report of Committee on Child Health

Warren W. Quillian, *Chairman*

A meeting of this committee was held at the Vinoy Park Hotel, St. Petersburg, on April 4, 1955 for the purpose of outlining and discussing plans for the coming year.

Activities, as usual, have been directed toward cooperative effort with existing agencies in the state for the betterment of child health.

Recent surveys indicate that accidents are the leading cause of death in the age group of one to fourteen years, exceeding in frequency the next six causes combined.[1] Many of these are preventable and are an adult responsibility. Prevention requires not only protection from the various hazards for the very young child but education to enable older children to live safely with these hazards.[2] Your committee is working with the sub-committee of the Florida Pediatric Society in the establishment of Poisoning Control Centers throughout the state. Here, at strategic locations, will be available at all times pertinent information concerning commercial and industrial products which may become potential poisons (if accidentally ingested), methods of diagnosis and facilities for proper emergency treatment. Designed primarily for use by the physicians of the community, these services may be utilized in time of need by any one. Our plan includes education by local physicians through parent-teacher groups, safety councils and school programs. The child must be taught to live safely with, rather than without, fire, water, machinery, drugs, electricity and chemicals. This field of effort constitutes a challenge for continued efforts toward prevention by every member of our Association.

The committee has participated during the year with the Bureau of Maternal and Child Health of the State Board of Health in their program to reduce neonatal mortality and morbidity. Members of the committee have served as lecturers at the Premature Centers in the program for training community nurses in this highly specialized field.

Many agencies want medical advice and guidance concerning the betterment of child health in Florida. Our committee believes that the most important function which we can perform is to render help when requested and to co-ordinate the work already begun in every section of the state. This is made possible

by the fact that our committee personnel is selected from each medical district.

Respectfully submitted,

Warren W. Quillian, *Chairman*

Councill C. Rudolph, M.D., St. Petersburg
William S. Johnson, M.D., Lakeland
Courtland D. Whitaker, M.D., Marianna
Ludo von Meysenbug, M.D., Melbourne

References

1. Dennis, J. M. and Kaiser, A. D.: Are Home Accidents in Children Preventable? Study of 491 Cases, Pediatric, 13:568 (June) 1954.
2. Dietrich, H. F.: Prevention of Childhood Accidents. What are we waiting for? J.A.M.A., 156:929 (Nov. 6) 1954.

Supplement

WHEREAS, there is an increasing incidence of poisoning in the United States and in the State of Florida, and

WHEREAS, the Florida Chapter of the American Academy of Pediatrics and the Florida Pediatric Society are attempting to remedy this situation by the establishment of poisoning control centers throughout the entire State of Florida,

BE IT THEREFORE RESOLVED, that the Florida Medical Association go on record as approving the work of these two Pediatric groups in the establishment and maintenance of such poisoning control centers.

Signed:
Florida Chapter of the American Academy of Pediatrics
Hugh A. Carithers, President, Jacksonville
Florida Pediatrics Society
Wesley S. Nock, President, Coral Gables
Committee on Child Health, Florida Medical Association
Warren W. Quillian, *Chairman, Coral Gables*

Dr. Quillian: "The report of the Temporary Committee on Blood, presented by Dr. Louis E. Pohlman, Chairman, is approved with the following comments: It is hoped that the recommendation incorporated in the report of the Board of Governors for By-Law change, providing for the establishment of a permanent Committee on Blood, be adopted by the Association. These recommended By-Law changes are described in your Handbook on page 33, paragraph 3.

"I move the report be adopted."

Seconded by Dr. Frederick H. Bowen.

Motion carried.

Report of Committee on Blood

Louis E. Pohlman, *Chairman*

A temporary Committee on Blood was appointed by Dr. John D. Milton to serve until the 1956 meeting of the House of Delegates.

During the year, the Florida Association of Blood Banks has expressed its enthusiasm as to the formation of such a committee by the Florida Medical Association. The chairman of the committee attended the national meeting of the American Association of Blood Banks, and it was found that most state medical associations now have standing committees on blood.

Information collected by a survey of all the blood banks in Florida showed a potential blood collecting and processing facility that is inadequate for large disasters. In relation to civil defense and the eventuality of atomic attack, blood collecting and processing facilities are grossly inadequate.

The recent formation of the Southeastern District Clearing House for the states of Florida, Georgia, Alabama, Tennessee, North Carolina and South Carolina have made possible the interchange of credits and a blood exchanging program helpful in disaster planning as well as day to day replacement program.

Florida is fortunate in the field of blood banking to have the present system of banks and the high standards of its existing facilities. This has made possible the present State Clearing House System and the present low rate of severe transfusion reactions.

Respectfully submitted,

Louis E. Pohlman, *Chairman*

Dr. Quillian: "The report of the Committee on Mental Health, presented by Dr. Sullivan G. Bedell, Chairman, is approved with the following amendments: (1) In paragraph 2, lines 6 and 7, page 21, change 'the position of State Commissioner of Mental Health' to read, 'the position of Commissioner of State Mental Institutions.' (2) In paragraph 3, omit: 'It is recommended that mental retardation and all mental illnesses be made reportable to the State Board of Health;' and this portion of the report be referred to the Committee on Legislation of the Florida Medical Association for further study and subsequent recommendation by them to the House of Delegates.

"I move we approve the report of the Committee on Mental Health and the supplemental report with the recommendation that the resolution in the supplemental report be referred to the Committee on Legislation for energetic prosecution."

Seconded by Dr. Clyde O. Anderson.

Motion carried.

Report of Committee on Mental Health

Sullivan G. Bedell, *Chairman*

The committee chairman attended the second annual conference of the Mental Health Representatives of State Medical Associations sponsored by the Council on Mental Health of the American Medical Association which was held at A.M.A. headquarters in Chicago, November 18 and 19, 1955. This meeting was particularly enlightening as to the activities of the Mental Health Committees of other state associations. Particularly stressed was the need for the aid of all practicing physicians in coping with the vast problems in the field of mental health.

The committee hopes to achieve a goal of having every county society appoint a mental health committee and plan to have at least one program each year on some subject related to the field of mental health. Other topics under study have been the establishment of the position of Commissioner of State Mental Institutions; practical approaches to the care of the senile psychotics; the establishment of the hospital at Arcadia as an independent state hospital; the advisability of making mental retardation a reportable disease and the possible need of changes in the laws relative to commitment of the mentally retarded.

Resolution

BE IT HEREBY RESOLVED, that the Florida Medical Association urgently recommend that funds

be provided for the completion of training facilities in psychiatry at the College of Medicine of the University of Florida;

AND, that upon its adoption, this resolution be transmitted to the Governor, the Cabinet and the Board of Control of the State of Florida.

Respectfully submitted,
Sullivan G. Bedell, *Chairman*

Report of Reference Committee No. 2

The Chair called for the report of Reference Committee No. 2, Dr. Francis H. Langley, Chairman.

Dr. Langley: "Reference Committee No. 2 met yesterday afternoon in the Boom Boom Room, with all members present; Drs. Chas. J. Collins, S. Carnes Harvard, Walter E. Murphree and Thomas C. Kenaston.

"The report of the Committee on Conservation of Vision, presented by Dr. Hugh E. Parsons, Chairman, is approved with the following amendments: Deletion of the third paragraph and the word 'further' in the first line of the fourth paragraph.

"I move the report be adopted as amended."

Seconded by Dr. Rowland E. Wood.

Motion carried.

Report of Committee on Conservation of Vision

Hugh E. Parsons, *Chairman*

Though no formal meeting of the Committee on Conservation of Vision has been held, most members have been contacted directly or indirectly concerning matters pertaining to this and to the Committee on Legislation and Public Policy.

Much anxiety was aroused by a bill which the Florida Optometric Association attempted to get passed which had to do with further defining their specialty and to prevent orthoptic clinics to operate except under their care. We believe the clinics belong as they are and not under the direction of the optometrists. Fortunately this bill was sent to the Senate Public Health Committee where it died. Representing ophthalmology in Tallahassee was Edson J. Andrews, of Tallahassee, who presented our objections commendably.

It is suggested that other branches of the medical profession be made aware of the symptoms and signs of glaucoma and assist in directing these patients properly. At best, glaucoma is a difficult disease with which to contend.

At this time the school children are checked at least once a year. This for the large part is done by home room mothers in their respective classes. Although some findings are far from correct, on the other hand many children previously unsuspected of having visual defects are found to have severe visual defects. Now, there is no excuse for children or adults going wanting for glasses or ophthalmic care. All qualified ophthalmologists have made their services available to such agencies as the Florida Council for the Blind, the Welfare Agency and the Lion's Club. These organizations do an excellent work in screening and rotating their patients.

Respectfully submitted,
Hugh E. Parsons, *Chairman*

Dr. Langley: "The report of the Committee on Medical Education and Hospitals, presented by Dr. Jack Q. Cleveland, Chairman, is approved, and in so doing the attention of the Board of Governors is called to the third paragraph.

"I move the report be adopted."

Seconded by Dr. James N. Patterson.

The Chair recognized Dr. Harry E. Beller of Dade.

Dr. Beller spoke in opposition to approval of this report, on the basis that it would establish a policy against Federal aid to medical education.

Dr. Louis M. Orr spoke in rebutal, explaining that the A.M.A. did not oppose "brick and mortar" aid by the Federal Government and that this report was not intended to disapprove that type of aid.

Motion carried.

Report of Committee on Medical Education and Hospitals

Jack Q. Cleveland, *Chairman*

Your Medical Education and Hospitals Committee did not have a meeting of the entire committee this year. Your chairman attended the American Medical Education Foundation State Chairmen's Meeting in Chicago on January 22, 1956. This meeting was very informative and helpful. The total contributions to the Medical Education Foundation from Florida in 1955 was $4,799.00. This was an increase over 1954 but is still, in the committee's opinion, an inadequate sum from over 2,000 doctors. As has been pointed out before, the money contributed to the Medical Education Foundation goes directly to the support of the 81 accredited medical schools in the United States. Of the amount contributed by the state, the Florida Medical Association Women's Auxiliary contributed over $2,000.

It is the opinion of your chairman that this Foundation fills a most vital need today. Since 1951 the National Fund for Medical Education and the American Medical Education Foundation have raised almost ten million dollars to assist medical schools. The medical profession opposes *continuing* federal aid for medical schools lest the government seek to control that which it finances. Medical research and education can flourish only in an atmosphere where creative initiative is unrestricted.

It is my feeling that this need is so pressing that an assessment by the Florida Medical Association should be discussed and explored.

Respectfully submitted,
Jack Q. Cleveland, *Chairman*

Dr. Langley: "The report of the Committee on Medical Economics, presented by Dr. Robert E. Zellner, Chairman, is approved through Recommendation VI; the remainder of the report has been submitted to Reference Committee No. 3.

"I move the report through recommendation VI be adopted."

Seconded by Dr. Chas. J. Collins.

Motion carried.

Report of Committee on Medical Economics

Robert E. Zellner, *Chairman*

The activities of the Medical Economics Committee this past year have been confined to two phases of

insurance of interest to the medical profession, i.e., professional liability insurance and disability insurance. One meeting of the committee was held in Jacksonville.

Professional Liability Insurance

At the last meeting of the House of Delegates six recommendations made by the Medical Economics Committee referable to professional liability insurance were adopted:

Recommendation I

The Association continue its efforts to acquire a satisfactory group professional liability insurance policy with a major insurance company whose financial soundness is unquestioned.

The firm of Marsh & McLennan, insurance brokers of New York, was retained at no cost to the Association to canvass the insurance market for an acceptable underwriter for the Association's group plan. These gentlemen presented our proposition to more than thirty leading insurance companies and have been unable to the present time to obtain an underwriter acceptable to the Association who will accept the risk on the terms specified by the Association. There is apparently a belief in the insurance industry that loss experience with professional liability insurance is worse than existing statistics indicate and until they are reasonably sure of the risk they are assuming no company is insuring a large number of risks on an unselective basis. Marsh & McLennan has advised the committee that the Association plan is a sound one and that efforts to obtain an underwriter for a group plan should be continued.

Recommendation II

The Florida Medical Association conduct a continuing program to educate its members in matters relating to the causes and prevention of suits for malpractice.

During the past year the chairman spoke on professional liability insurance and the malpractice problem before three county medical societies whose membership comprise more than one-third of the Association membership and at three of the four district medical meetings. Reference has been made to the malpractice problem in several issues of The Journal. It is recommended that the insurance committee of each county medical society present to its society at least one program each year on the cause and prevention of suits for malpractice. It is further recommended that publicity be given to the existence of Grievance Committees so that a dissatisfied patient may have his complaints heard without resorting to a court of law.

Recommendation III

The Association begin to collect its own statistics of losses incurred in Florida from malpractice suits and threats of suits.

Letters have been written to each county society asking for this information. The response to date has not been good. Some societies have replied promptly and in detail, but a majority has not responded at all. At present forms are being prepared to be sent to each society so that the returns from the questionnaire can be standardized.

Recommendation IV

The Association recommend that the by-laws of each county medical society be amended to the effect that it will be mandatory that each member of the society report to the society immediately any threat of malpractice suit. The society should collect all pertinent data in the case and notify the Association office immediately. When the case is concluded the total amount of money expended for fees, court costs, damages, etc., should be ascertained and recorded at the Association office.

The committee does not know at the moment to what extent this recommendation has been carried out.

Recommendation V

Each county medical society organize an insurance committee for the purpose of assisting the insurance underwriter in ascertaining the facts in all threats of suits for malpractice against its members and in advising the threatened physician and the underwriter as to the proper disposition of the case.

Several societies have appointed insurance committees and some are functioning. The committee plans to poll the societies to learn which have insurance commitees and which do not. It is the belief of the Medical Economics Committee that the individual society insurance committees should function in matters pertaining to insurance as the legislative committees do in matters related to legislation in keeping the entire membership of the societies informed. The education program can best be accomplished on a county level through the insurance committee and it is not necessary to wait for a suit before the committee begins to function.

Recommendation VI

Each county society take action through the Board of Censors, or other appropriate committee, against any of its members whose actions have been responsible for unwarranted exposure of another physician to the charge of malpractice.

The committee does not know how effectively the county societies are carrying out this recommendation although it has been informed that at least one of the larger societies is effectively policing its membership in this respect.

These recommendations are just as valid and just as important in 1956 as they were in 1955, and the committee urges that those county societies who have not complied with them to date do so as soon as possible.

Group Disability Insurance*

The second phase of the committee activities has been in the field of disability insurance. Several insurance brokers in the past year have presented plans for group disability insurance for the members of the Association. When it was decided to investigate this matter further the committee drew up certain specifications for a contract which it felt would provide the greatest amount of protection for the greatest number of members for the lowest cost. More than twenty-five insurance companies were asked to make a proposal and the proposals of three brokers were considered by the Medical Economics Committee on January 15, 1956. The plan selected was one proposed by Marsh & McLennan and underwritten by Continental Casualty Insurance Company. This contract offers several features which are not usually available in group disability contracts:

1. Graded premium rates. As in life insurance, different rates apply at different ages. In a level premium policy, the rate-applicable from age fifty to sixty is that used for all ages. Since 66 per cent of the membership of the Florida Medical Association is less than fifty years of age, and 85.6 per cent less than sixty, a graded premium will represent substantial savings to a considerable majority.

2. Optional two or five years coverage for sickness and lifetime for accident. Since 98 per cent of all disability for illness terminates within two years the committee felt that the membership should be offered the economy of a shorter term of coverage. For those who prefer the longer term it is available at extra cost.

3. Excess medical coverage. An option available at extra, but low, cost is one which provides for the payment of all hospital expense in excess of $500 up to $5,000.

The committee feels that this contract offers to the members of the Florida Medical Association the finest in group disability insurance and that it should provide protection at low cost in addition to that now available through other sources.

In conclusion, I would like to say that the members of this committee are "working" members with each one carrying his load. I would like to express my personal appreciation to each of them, to Dr. Milton, to Dr. Day and to Mr. Gibson, for their advice, assistance and efforts in behalf of the committee.

Respectfully submitted,

Robert E. Zellner, *Chairman*

*This portion of the report was approved concurrently with approval of the identical proposal contained in the Supplement to the Report of the Board of Governors by Reference Committee No. 3.

Dr. Langley: "The report of the Committee on State Controlled Medical Institutions, presented by Edward H. Williams, Chairman, is approved.

Dr. Milton: "I am going to rule that this report be read, because it was not read yesterday. I don't see how we can act on something we know nothing about."

Dr. Langley read the report.

Dr. Langley: "I move the report be adopted."

Seconded by Dr. Sidney G. Kennedy Jr.

Motion carried.

Report of Committee on State Controlled Medical Institutions

Edward H. Williams, *Chairman*

This committee of five (5) Presidential appointees under Section 13 of the Constitution and By-laws is charged with the task to "investigate medical personnel and medical requirements of all state or public institutions and recommend such changes and improvements as they deem necessary for the most efficient operation of such institutions."

The function of this committee is thus spelled out. However, it is not clear which ones are to be so investigated. By custom, this committee inspects the State Hospital at Chattahoochee, the branch at Arcadia, and the Farm Colony at Gainesville. Lately, the new hospital west of Hollywood has been added, and this committee has included the Alcoholic Rehabilitation Program's Hospital near Avon Park.

This committee met to organize April 4, 1955 but a quorum was not present. To date, it is unorganized and the chairman assumes full responsibility for this failure.

Nevertheless, each institution listed above has been visited by the undersigned during this year and reports received, except for the branch of the Hospital at Arcadia. This was inspected in a previous year.

The basis of the judgments to follow rest upon two broad criteria:

a. the inspectors twenty-five (25) years in clinical psychiatry, eleven (11) of which were in institutional settings;
b. the Standards for Psychiatric Hospitals and Clinics, American Psychiatric Association, Revised, 1954.

Having investigated the facilities at Chattahoochee before, I am convinced there is much to be found that is favorable. For example, the superintendent is a physician, a qualified psychiatrist, and obviously a dedicated public servant above the call of his job. Generally, his personnel possess similar qualities. The physical plant is neat and clean. New buildings are evident. Part are replacement for long out-moded quarters; part are for expansion of present facilities. I question the wisdom of the latter in terms of efficient operation and in terms of still existing grossly inadequate structures housing sick humans.

Modern treatment facilities and procedures are utilized on the patient population by earnest personnel. There is judicious spread of personnel in relationship to the overall patient care, as a general statement.

Conversely, there is serious overcrowding of patients in most pavillons. There is a "waiting list" for patients (Sic). This institution is too large; it cannot be operated efficiently. The responsibilities, even for so dedicated a superintendent, are most unreasonable. Worse, however, is the fact that the sick people come in faster than they can be discharged; slowly but surely the struggle is being lost.

At Arcadia, there is nothing new in reality. The superintendent is a longtime and devoted physician in the State Service. The buildings are newer but the patients are more chronic psychiatric problems in the main. The rate of discharge is quite low. In fairness, the personnel tries to get the job done but how should this be rated?

Improvement is the keynote describing the care of patients at the Farm Colony. While this extends to the educational aspect it is not as impressive as in the medical side. Two unselfish physicians try to care for 1124 patients, largely young children, including infants. Obviously, this is impossible, but they make a Herculean effort. They do a remarkable job; I felt a twinge of embarrassment, professionally speaking. The auxiliary personnel was impressive also with much T.L.C. (tender loving care) in evidence. There is much badly needed new construction finished or under way.

The entire physical plant is neat and clean in appearance; it is spread out too much, however, for efficient operation. It is clear this institution has been the most seriously neglected of the entire State System and is just beginning to receive consideration. Again, the long "waiting list" of sick people best summarizes conditions found. Only 10% —I repeat—only 10% of such patients can be taken per annum. The problems here can go only one way—up and up—under present conditions. The superintendent is a layman, a long time career man in State Service. Without reference to him personally, this is a mistake of the first magnitude and unfair to all concerned. There is no consulting staff, psychiatric or non-psychiatric; this is a serious oversight and should be rectified now.

The new hospital for alcoholics is assuming form. The bed capacity is 100 and construction was estimated about 60% complete. The conception of the plant appears sound and seems adequate. Whether it is functional could not be determined.

The location of this hospital near Avon Park was understandable since the land was a gift to the State, but as an operation the choice will prove a mistake of some proportion. Responsibility is invested in a layman with a 60% lay board over him. Of course, this is unfortunate, but then we in the profession did not provide leadership in this area of responsibility. Nevertheless, this should be done now!

The new South East State Hospital is scheduled to be finished and occupied by patients about January, 1957. The plant is sound in concept and permits much flexibility. For example, additional patient units can be added at minimal cost. Also, the present plant can be modified at minimal cost and without interruption of treatment. The new superintendent has been on the scene for some time for personal orientation, and overall planning and organization. This was a wise move; the State has profited thereby. He is an experienced physician, psychiatrist, and psychiatric hospital administrator. The future of this institution is such as to justify optimism that minimal requirements will be met and its operation will be efficient.

In summary, this committee, therefore, finds that there is an overall lack of planning, organization, and supervision of State Controlled Medical (Mental) Institutions. Thus, an efficient operation is not possible, and even minimal standards are not being met. For the financial-minded, this operation is big business; about $35,000,000 worth per bi-ennium, a reliable source tells me. This is further brought in be-

cause we taxpayers own this business or we are stuck with it, depending on the point of view.

Accordingly, it is recommended that a qualified commissioner of State Mental Institutions be employed and, further, that he be given sufficient authority, free from political influence, to correct these conditions and to enable him to discharge the obligations of his position with professional dignity.

I conclude this report by expressing my appreciation for the privilege of serving on this committee and my gratitude for same is hereby acknowleged.

Respectfully submitted,
Edward H. Williams, *Chairman*

Dr. Langley: "The report of the Committee on Representatives to Industrial Council, presented by Dr. John H. Mitchell, Chairman, is approved with the recommendation that a liaison committee of three physicians be appointed to meet with three representatives of the insurance industry to adjudicate differences regarding fees.

"I move the report be adopted."

Seconded by Dr. Jere W. Annis.

Motion carried.

Report of Representatives to Industrial Council

John H. Mitchell, *Chairman*

Your Committee has gone over the previous reports of past years and they are all very conspicuous by the fact that "so little has ever been suggested or followed through." As chairman, I have had the privilege of attending the Congress on Industrial Health sponsored by the A. M. A., held in Detroit, Mich., Jan. 22-24, 1956. I have studied the activities of committees in other states where there are active programs pertaining to industrial health and have come up with the following suggestions:

1. It is common knowledge that insurance carriers are frequently complaining about the activities or charges of certain doctors. On the other hand many doctors are forever complaining about the practices of certain claims representatives and their casualty company practices.

We suggest that the Florida Medical Association establish an Arbitration Committee consisting of the chairman of the Committee on Industrial Health and two members of that committee to meet with three appointed members from the Florida State Claims Managers Association. These six men would constitute a committee to which would be referred any dispute between industrial physicians and insurance carriers on any questions which might arise concerning both groups.

It is our further suggestion that when a grievance committee of the county medical society does exist that the matter should first be brought to its attention. If it cannot be resolved there then it would be carried to the state committee. This encourages the local committee to be more active. The fact that such a committee is active and working is a source of comfort and satisfaction to the employee, the employer, the insurance carrier and the physician.

(Note: This plan is in operation in several of the highly industrialized states and is proving very satisfactory.)

2. There are health problems in many industries and modern industry is concerning itself more and more with fringe benefits in various health programs. Some of these can have profound and lasting effects on the mode of medical practice, its financing and administration.

It is our suggestion that a committee be appointed to study and set up "Adoption of Guiding Principles to Govern Lawful and Ethical Extension of Medical and Health Services to Employed Workers."

Florida is rapidly becoming an industrial state and now is the time for the doctors themselves to face certain problems which to us are entirely new. We should provide a source of consultation on subjects of medical interest to agencies and other groups such as labor, management, insurance, public agencies and voluntary health organizations.

Respectfully submitted,
John H. Mitchell, *Chairman*

Dr. Langley: "The report of the Committee on Grievance, presented by Dr. Herbert E. White, Chairman, is approved as published in the Handbook.

"I move the report be adopted."

Seconded by Dr. George W. Morse.

Motion carried.

Report of Grievance Committee

Herbert E. White, *Chairman*

Your grievance committee has had very few complaints this year; as a matter of fact, the smallest number of complaints since the committee was organized. This probably can be attributed to two reasons:

1. Our original chairman, Dr. Walter C. Payne Sr., who served ably for five years left very little to be cleared up by your present committee;
2. The local county grievance committees apparently are handling these cases on a local level and are satisfying the complainants, which has meant that they were not referred to the state committee.

The majority of the complaints that the state committee has received this year, in all probability, are the results of a misunderstanding between the doctor and the patient as far as the fees are concerned. The rest of the complaints are the results of improper diagnosis of the patient's illness. It is not always possible to make a correct diagnosis, but we feel that the doctor involved should be frank in telling the patient the impossibility of making the correct diagnosis in every case, and at least assume some of the responsibility for the mistake. There are a few complaints which have not been settled, but it is your committee's hope that the local committees will do everything possible to handle these complaints for the best interest of the medical profession.

I would like to take this opportunity, as the oldest member of the committee, to express my appreciation for the cooperation of the members of this committee and those of the county grievance committees.

Respectfully submitted,
Herbert E. White, *Chairman*

Dr. Langley: "The supplemental report of the Temporary Committee on Nursing, presented by Dr. Jere W. Annis, Chairman, is approved with the following amendments: Addition to the supplemental report of the final paragraph of the original report (with the first paragraph of the original report deleted); the chairman of each county committee on nursing be invited to meet with the state committee on nursing annually and feel free to call upon the district member of the state committee at any time for advice and assistance.

"I move the report be adopted as amended."

Seconded by Dr. Karl B. Hanson.

Motion carried.

Report of Committee on Nursing

Jere W. Annis, *Chairman*

During the past two days this committee has discussed at length many of the nursing problems arising in the state, and the committee deplores what it feels to be a socializing or trade union influence creeping into the state nursing association. We feel certain this is not representative of the opinion of the majority of individual nurses throughout the state, but rather representative of a recent undesirable outside influence.

It is our hope that in the future, before the state nurses association embarks on any program to change policies or to investigate problems which are of mutual concern to both nurses and physicians, they will consult with this committee of the Florida Medical Association in order to reach a consolidated opinion mutually beneficial and in the best interest of the patient. We feel this will further better public relations for us all and will result in better patient care. We refer here specifically to the problem of doctors' office assistants.

We also suggest that the nurses association avail themselves of the opportunity of such consultation on any matters involving the change of any established policy, professional or ethical, which may arise, as well as on any legislative changes affecting nursing practice.

Traditionally the members of our two great professions have worked hand in hand for the benefit of the sick patient to whom we are both dedicated. We regret that we have drifted apart and deplore the loss of the high ideals of our respective professions, wherever they may have occurred. We urge a return to these principles and these ideals.

We suggest and recommend that a reunion of our professions might be best accomplished by the establishment within each county medical society of a committee on nursing.

Such a committee would devote such time as necessary to the study of mutual problems and to the professional instruction and education of nurses in all categories, i.e., professional and practical, in order to improve the ultimate nursing care to the patient. We feel that at this local level differences can be settled and policies discussed on a friendly and personal basis to the mutual benefit of all. We feel that the accomplishment of this is of the utmost importance in the maintenance of good public relations between the medical profession and the patient.

If this supplemental report is adopted, we respectfully request that copies of it be furnished to all professional nursing organizations within the state, including district organizations, and to the practical nursing association of the state as well as to the component medical societies of this Association.

In respect to the State Nursing Association's recent request for contributions to help with the program of inducing additional girls to enter the field of nursing, I feel that it might perhaps be wise for the state medical association to contribute the sum of $100 as per request of the letter of June 23, 1955.

Respectfully submitted,
Jere W. Annis, *Chairman*

Dr. Langley: "The resolution on Review of Working Agreement with the National Foundation for Infantile Paralysis, presented by the Sarasota County Medical Society, is not approved. The reason is that the situation has resolved itself.

"I move the resolution be disapproved and not published in The Journal."

Seconded by Dr. Thomas C. Kenaston.

Motion carried.

Dr. Langley: "The resolution on Studies on Degrees of Indigency, presented by the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society is disapproved. The reason is because the magnitude of such a study renders it impractical.

"I move the resolution be disapproved and not published in The Journal."

Seconded by Dr. Robert E. Zellner.

Motion carried.

Dr. Langley: "The resolution on Advertising on Prescription Blanks, presented by the Pinellas County Medical Society, is approved as printed in the Handbook.

"I move the resolution be adopted."

Seconded by Dr. A. Judson Graves.

Motion carried.

Resolution

Advertising on Prescription Blanks

WHEREAS, 30 per cent of the people contacted by the Pharmaceutical Association believe physicians receive cut-backs on prescriptions bearing pharmacists' advertising,

BE IT RESOLVED, that the matter be presented to the House of Delegates of the Florida Medical Association for expression of opposing the use of advertising on prescription forms.

Exacted by the Board of Govenors of the Pinellas County Medical Society Inc., in regular session November 7th, 1955.

Respectfully submitted,
Whitman C. McConnell, *Secretary*
Pinellas County Medical Society

Dr. Langley: "The resolution on Relationship between Medical School Faculties and Physicians of the Community, presented by the Alachua County Medical Society, is approved in spirit and referred to the Committee on Medical Education and Hospitals to act in conjunction with the Medical Advisory Committee of the University of Florida for further study, and report back to the Board of Governors by the first of September, 1956.

"I move this recommendation be adopted."

Seconded by Dr. Clyde O. Anderson.

Motion carried.

Dr. Langley: "The resolution concerning the Florida State Board of Medical Examiners, presented by the Broward County Medical Association is not approved.

"I move the resolution be disapproved and not published in The Journal."

Seconded by Dr. Chas. J. Collins.

The Chair called for a voice vote which was inconclusive.

Dr. Jere W. Annis asked that the resolution be read.

Dr. Langley read the resolution.

Dr. Milton: "It would take an act of the

Legislature to change the present procedure."

The Chair recognized Dr. Franklin J. Evans of Dade.

Dr. Evans: "I am at a loss to understand why the Reference Committee opposed the passage of this resolution. It is certainly not controversial and is intended to improve standards of doctors applying for membership in the county medical societies. We have been repeatedly embarrassed by having men apply for membership, who have been licensed by the Board of Medical Examiners and on further investigation we have found that these men received their degrees from non-approved medical schools. We certainly don't mean to criticize the State Board of Medical Examiners but we think that one of the reasons this has happened is that the medical examiners have not had enough time to investigate each applicant and consider all of the factors involved.

Dr. Russell B. Carson: "We did not intend to raise a controversy in presenting this resolution. It was intended to try to assist the State Board of Medical Examiners by a suggestion from this body that more time be granted for the investigation. It may be that in certain parts of the state you are getting the 'cream of the crop.' I can tell you that we are far enough down the coast that some of the 'cream' has been skimmed off. We are not proposing that any changes be made in the legislative act by this resolution. Perhaps the Board would desire that that be done but we are merely requesting that further study be given to candidates, and if possible, that further time be allowed between receipt of the application and the time they take their examinations. I don't think a thorough study of some 300 applicants can be made by the Board within a 30 day period and that is about the length of time they have between the Basic Science examination and the time for the State Board examinations. I hope that you will reconsider the action of the Reference Committee and it might be enlightening to us for the Reference Committee Chairman to summarize the reasons why the Reference Committee refused to recommend adoption."

Dr. David Kirsh: "In Dade County, there is even less 'cream.' We have discovered there are three members of our county society who were permitted to take the medical examinations who are graduates of osteopathic schools and received an M.D. from a diploma mill. We offer this not as criticism but as a plea that they have more time and more facilities to screen the applicants."

Dr. Langley: "Dr. Pearson was present at the Reference Committee and discussed this matter. He stated that they make a check in various ways through the medical school, through his former county society, where a doctor previously held membership in a county society, they check other references and check through the A.M.A. He stated that much of the difficulty dates back to the period when there was a provision made by law for handling graduates of non-approved medical schools, provided the doctor took sufficient graduate study to make up the deficiency. That has been changed in the law, and doctors are now required to be graduates of approved medical schools. Dr. Pearson thought that 30 days was sufficient. On the basis of Dr. Pearson's testimony, the Committee made its recommendation."

Dr. Milton: "The voice vote was not conclusive. We will have a standing vote."

Motion lost by a vote of 74 to 51.

Dr. Carson: "I move the resolution be approved."

Motion seconded.

Dr. Hampton: "I rise for information and request to be advised as to whether this will require the Legislative Committee to submit a bill to the next Legislature to change the Medical Practice Act."

Dr. Milton: "No, this is for study."

Motion carried.

Resolution

WHEREAS, there is a steadily increasing number of physicians applying to the Florida Board of Medical Examiners and

WHEREAS, there is evidence that there has been insufficient investigation of the backgrounds of candidates seeking Florida licensure:

BE IT THEREFORE RESOLVED, that the Florida Medical Association petition the board of medical examiners to investigate more carefully the qualifications of applicants and to close the deadlines for such applications sufficiently far in advance to complete these investigations and

BE IT FURTHER RESOLVED, that if funds are insufficient to cover costs of careful study of previous records, the examination fee be raised sufficiently to meet these costs.

Respectfully submitted,
Burns A. Dobbins Jr.
Chairman of Delegates
Broward County Medical Associtaion

Dr. Langley: "The resolution on Medical Practices presented by the Orange County Medical Society is approved as read.

"I move the resolution be adopted."

Seconded by Dr. Ralph Herz.

Motion carried.

Resolution
Medical Practices

WHEREAS, The House of Delegates of the American Medical Association adopted the accompanying Resolution on Medical Practices at the Boston Meeting on December 1, 1955; and

WHEREAS, The application of these principles must be by the state associations and by the local county medical societies; now therefore be it

RESOLVED, That the House of Delegates of the Florida Medical Association endorse this Resolution on Medical Practices.

Respectfully submitted,
W. Ansell Derrick, *Secretary*
Orange County Medical Society

(Resolution on Medical Practices Adopted by the House of Delegates of the American Medical Association at Boston in December, 1955.)

WHEREAS, The report of the Committee on Medical Practices was presented to this House of Delegates in June, 1955, in which the committee has completed its intensive study of the basic causes leading to certain unethical practices and to unfavorable publicity; and

WHEREAS, The findings and recommendations of this committee deserve intensive study by the physicians of this country and by the American Medical Association, who should consider their rather wide ramifications and the feasibility of their practical application; and

WHEREAS, The House of Delegates of the American Medical Association in 1947 resolved that "It was never intended that staff appointments in hospitals generally, or even in hospitals approved for residencies, should be limited to board certified physicians as is now the policy in some hospitals. Such policies, if practiced extensively, are detrimental to the health of the people and therefore to American medicine. Hospital staff appointments should depend on the qualifications of physicians to render proper care to hospitalized patients as judged by the professional staff of the hospital and not on certification or special society membership"; now therefore be it

RESOLVED, That a Continuing Committee on Medical Practice be created in the American Medical Association to conduct a study of the relative value of diagnostic, medical, and surgical services and to report its findings and recommendations to this House in the same manner as is now followed by other committees and councils of the Association; and be it further

RESOLVED, That this committee shall consist of five members of the House appointed by the Speaker, three of whom shall be general practitioners; the terms of the members of this committee shall ultimately be three years, arranged at the discretion of the Speaker in his original and subsequent appointments so that these terms shall be staggered; and be it further

RESOLVED, That this committee be directed to utilize all possible means to stimulate the formation of a department of general practice in each medical school; and be it further

RESOLVED, That the American Medical Association approve of the medical school teaching programs which afford the medical student opportunity for experience in the general practice of medicine; and be it further

RESOLVED, That, subject to review by counsel of the American Medical Association, the representatives of the Association on the Joint Commission on Accreditation of Hospitals be instructed to stimulate action by that body leading to the warning, provisional accreditation, or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class regardless of their individual professional competence, after appeal to the Commission by the county medical society concerned; and be it further

RESOLVED, That this committee cooperate in every way and assist the Public Relations Department of the American Medical Association to present a program of public education designed to bring about a better understanding of all fields of medical practices; and be it further

RESOLVED, That this committee use its full influence to discourage any arbitrary restrictions by hospitals against general practitioners as a group or as individuals; and be it further

RESOLVED, That a copy of this resolution be sent to the American College of Surgeons, the American College of Physicians, the American Academy of Pediatrics, the American Academy of Obstetrics and Gynecology, the American Academy of General Practice, the American Hospital Association, the Catholic Hospital Association, the American Protestant Hospital Association, the chief of staff of every hospital in the United States and its territories, the deans of each medical school, and promptly to the editor of each state medical journal.

Dr. Langley: "The resolution on the policy of state hospitals presented by the Manatee County Medical Society is not approved in view of the fact that such information may be obtained upon request.

"I move the resolution be disapproved and published in The Journal. The reason for publishing this resolution is to bring to the attention of the membership that this information will be furnished upon request. It would place a heavy burden on the small staff of doctors in our state hospitals to make these reports on every patient. Also, many of the patients are not referred by a private physician but by some state board. They will gladly send this report to anyone who requests it. Also, these doctors state that they frequently have trouble in getting medical histories from physicians who refer patients to the state hospitals."

Seconded by Dr. Cecil M. Peek.

Motion carried.

Resolution (Unapproved)
Policy on State Hospitals

WHEREAS, it is the desire of referring physicians to cooperate fully with Florida State Hospitals, and

WHEREAS, at the present time there is no State policy in reporting progress and treatment of patients,

THEREFORE BE IT RESOLVED by the Florida Medical Association that: All State Hospitals provide an admission and discharge summary to the referring physician or physicians on all patients sent to these hospitals in order to provide the referring physician with an admission diagnosis, discharge diagnosis, and a suggested outline of continued therapy.

Respectfully submitted,
Richard V. Meaney, *President*
Manatee County Medical Society

The Chair recognized Dr. Walter W. Sackett Jr., Chairman of the Necrology Committee.

Dr. Sackett: "When I was asked to be chairman of this committee, one suggestion was that we have a more fitting and proper memorial service for our deceased members. To that end, I have

brought you today a beloved figure of Miami Beach — the Right Reverend Monsignor William Barry.

Monsignor Barry conducted a beautiful and touching requiem, ending with the Lord's Prayer.

Report of Reference Committee No. 3

Dr. Louis M. Orr, Chairman of Reference Committee No. 3, Finance and Administration, was recognized and asked to present the report of that committee.

Dr. Orr: "Reference Committee No. 3 met in the North Card Room, with all members present: Drs. Russell B. Carson, Samuel M. Day, George W. Morse and Donald W. Smith.

"Our meeting lasted from 2:30 p.m. to 6:40 p.m. in an atmosphere not unlike trying to have a meeting on the corner of 5th Avenue and 42nd Street. There was a very spirited bridge game on one side of us and the hotel employees walking back and forth on the other."

"The resolution on Expenses of Association Officials, presented by the Orange County Medical Society, and the similar resolution presented by the Broward County Medical Association, were considered jointly. The Committee is in sympathy with these resolutions, but after long and careful deliberation and a review of the Association's resources, the following is recommended:

"That the resolution presented by the Orange County Medical Society be approved in principle, but that paragraph 4 and 5 be deleted, and substitute therefor:

"Be It Therefore Resolved, that the Board of Governors be authorized to establish in the budget a fund for the President or his designated representatives (which may include committee chairmen), not to exceed $1,500, and for the Secretary or his designated representatives, not to exceed $1,000, for expenses incurred in traveling on Association business, and that the Board continue its study relating to expenses for other officers and committee chairmen.

"I move for adoption of this portion of the report as amended."

Seconded by Dr. Morse.

Motion carried.

Resolution

Expenses of Association Officers

WHEREAS, the operation of the Florida Medical Association is of such magnitiude as to require the frequent and repeated attention of its officers, and

WHEREAS, the duties of an officer of the Florida Medical Association not only necessitate a sacrifice of time lost from practice but actual out-of-pocket money in travel, hotel, and other expenses to the office holder and

WHEREAS, the entire membership of the Florida Medical Association derives benefit from the services of its officers:

BE IT THEREFORE RESOLVED that the Board of Governors be authorized to establish in the budget a fund for the President or his designated representatives (which may include committee chairmen), not to exceed $1,500, and for the Secretary or his designated representatives, not to exceed $1,000, for expenses incurred in traveling on Association business, and that the Board continue its study relating to expenses for other officers and committee chairmen.

Respectfully submitted,

W. Ansell Derrick, *Secretary*
Orange County Medical Society

Dr. Orr: "The resolution on Invitation for the 1957 Annual Meeting, presented by the Broward County Medical Association, is approved with appreciation.

"I move this portion of the report be adopted."

Seconded by Dr. Burns A. Dobbins Jr.

Motion carried.

Resolution

Invitation for 1957 Annual Meeting

WHEREAS, Broward County has adequate facilities to act as host for the Florida Medical Association at the Hollywood Beach Hotel and

WHEREAS, it will have been three years in 1957 since the Broward County Medical Association has been host to the Florida Medical Association:

BE IT THEREFORE RESOLVED, that the Broward County Medical Association extend a cordial invitation to the Florida Medical Association to hold the 83rd annual meeting at the Hollywood Beach Hotel.

P.S.—This resolution extending an invitation for the 1957 meeting is to be in no way construed as an invitation to take up residence in Broward County.

Respectfully submitted,

Burns A. Dobbins Jr.
Chairman of Delegates
Broward County Medical Association

Dr. Orr: "The resolution on a State Physicians Committee on Blue Shield, presented by Dr. Russell B. Carson, President of Blue Shield, is approved with the following amendments: The second paragraph be changed to read:

"Be It Further Resolved that the Committee consist of a state chairman to be appointed annually by the President of the Florida Medical Association, and sixteen members, two from each of the eight Councilor Districts, appointed by the President of the Florida Medical Association, four for one year, four for two years, four for three years and four for four years, and thereafter they shall be appointed for a term of four years as the terms expire.

"It is further recommended that consideration be given to the appointment of doctors who are participating members of Blue Shield, and, when practicable, active members of the county medical

society insurance committees. It is further recommended that the various fields of medicine be represented.

"I move that this portion of the report as amended be adopted."

Seconded by Dr. H. Phillip Hampton.

Motion carried.

Resolution

State Physicians Committee on Blue Shield

RESOLVED THAT the Board of Directors of Blue Shield of Florida, Inc. do hereby request that the House of Delegates of the Florida Medical Association establish a State Physicians Committee on Blue Shield to act as (a) Advisory to Blue Shield and (b) as a Reference Committee, on problems of fee schedules, patient claims, new contracts, contract modifications and similar problems wherein physicians are involved or interested.

BE IT FURTHER RESOLVED that the Committee consist of a State Chairman to be appointed annually by the President of the Florida Medical Association and sixteen members, two from each of the eight councilor districts, appointed by the President of the Florida Medical Association, four for one year, four for two years, four for three years and four for four years, and thereafter they shall be appointed for a term of four years as the terms expire.

It is further recommended that consideration be given to the appointment of doctors who are participating members of Blue Shield and, when practicable, active members of the county medical society insurance committees. It is further recommended that the various fields of medicine be represented.

Respectfully submitted,
Russell B. Carson, *President*
Blue Shield of Florida, Inc.

Dr. Orr: "The resolution on dates for the Annual Meeting, presented by the Broward County Medical Association, is approved. The Board of Governors, insofar as possible, endeavors to set the dates of the Annual Meeting in April.

"I move that this portion of the report be adopted."

Seconded by Dr. Carl S. McLemore.

Motion carried.

Resolution

Dates of Annual Meeting

WHEREAS, the annual meeting of the American Medical Association is always held in June and

WHEREAS, many delegates and members of the Florida Medical Association attend both the American Medical Association and the Florida Medical Association meetings and

WHEREAS, necessary legislation has been adopted permitting convention sites to be selected two years in advance:

BE IT THEREFORE RESOLVED, that the Broward County Medical Association request that insofar as possible the dates of the annual meeting of the Florida Medical Association be set in April of each year so that it will not be necessary for delegates and members to be out of their offices on successive months.

Respectfully submitted,
Burns A. Dobbins Jr.
Chairman of Delegates
Broward County Medical Association

Dr. Orr: "The report of the Committee on Necrology, with two supplemental reports, presented by Walter W. Sackett Jr., Chairman, is approved with the following amendments: The Committee suggests that when a Past President or other officer of the Association dies, special mention be included in the Necrology report. Supplement No. 1, which listed additional deaths, is approved. Supplement No. 2 is disapproved.

"I move that this portion of the report as amended be adopted."

Motion seconded and carried.

Report of Commitee on Necrology

Walter W. Sackett Jr., *Chairman*

During the last fiscal year our Association lost by death the members whose names are listed below:

Claude Anderson, Fort Myers
Emory W. Bitzer, Hernando
Raymond S. Camp, Gainesville
William C. Chowning, New Smyrna Beach
Michael P. DeBoe, Miami
George H. Gwynn Jr., Tallahassee
Harry B. Haisfield, Pensacola
Frank M. Hall, Gainesville
Leo Honigsberg, Miami Beach
Joseph B. Kollar, Hudson, Ohio
P. T. McClellan, Vero Beach
Alice R. Miller, West Palm Beach
Claude C. Pearce, Mulberry
Edgar Peters, Miami
Harry Z. Silverman, Miami Beach
Richard M. Stitt, St. Petersburg
H. Marshall Taylor, Jacksonville
Clarence R. Wilcox, Jacksonville
J. Maxwell Williams Jr., Tampa
Will L. Wood, New Smyrna Beach

When possible, obituaries have appeared in *The Journal* relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they have practiced.

Supplement

Since the Handbook went to press, the following members have been lost by death:

Chas. W. Bartlett, Tampa
Reuben N. Burch Sr., Miami
Lawrence A. Cleverdon, Stillwater, Oklahoma
William M. Davis, St. Petersburg
C. J. Golinvaux, Surfside
Robert P. Henderson, Orlando
David G. Humphreys, Fernandina Beach
Valentine E. Jenkins, Miami Beach
Blake M. Lancaster, Manatee
George M. Mitchell, Jacksonville
William S. Nichols, Lake City
J. J. Spencer, St. Augustine

Respectfully submitted,
Walter W. Sackett Jr., *Chairman*

Dr. Orr. "The report of the Committee on Advisory to Woman's Auxiliary presented by Dr. Wiley M. Sams, Chairman, is approved.

"I move that this portion of the report be adopted."

Seconded by Dr. Sidney G. Kennedy Jr.

Motion carried.

Report of Committee on Advisory to Woman's Auxiliary

Wiley M. Sams, *Chairman*

The Woman's Auxiliary will submit its annual report to the Florida Medical Association later in the spring.

The usual activities of the Auxiliary have been continued. The first Year Book for the Florida Woman's Auxiliary was published during the past year. Correspondence and advice concerning policy for the Nurse Recruitment Program and Future Nurses' Clubs was submitted and suggestions regarding expansion of these projects were offered.

A continued discussion regarding management of funds which were collected by the Auxiliary for their various objectives was submitted to the accountant for his advice regarding taxable income which might accrue to the organization. These activities are considered to be charitable enterprise and a ruling to this end is desirable.

The Auxiliary has continued its interest in obtaining subscriptions to "Today's Health" and contributions to the American Medical Education Fund. Their work in many other community projects is difficult to evaluate, yet the public relations value which the interest of members of the Auxiliary create is a definite asset to organized medicine.

Respectfully submitted,
Wiley M. Sams, *Chairman*

Dr. Orr: "The report of the Council with its supplement, presented by Dr. Ralph W. Jack, Chairman, is approved with the following amendment: That the last paragraph of the supplemental report be deleted. The Committee believes that it should be optional with the Chairman of Council whether he wishes to invite the Deans of the two Medical Schools to report at the District Meetings.

"I move this portion of the report as amended be adopted."

Seconded by Dr. W. Dean Steward.

Motion carried.

Report of Council

Ralph W. Jack, *Chairman*

The Council met in St. Petersburg during the meeting of the Florida Medical Association. At this time a general outline of work for the Council for the ensuing year was established and the general plans for the District Meetings early in October were made.

The 16th annual Medical District Meetings were held in Fort Lauderdale on October 10, in Lakeland on October 11, at Gainesville on October 12 and at Pensacola on October 14. The scientific programs were held in the form of symposiums on subjects of wide general interest. The same general subjects were used in each District, the speakers being doctors from the respective districts. The moderator for each panel in all four meetings were the guest scientific speakers, Dr. George T. Harrell, Jr., of Gainesville, Dean of the College of Medicine, University of Florida and Dr. James J. Griffitts of Miami, President of the American Association of Blood Banks and Associate Director of the John Elliott Blood Bank of Dade County. The details of each meeting are presented in The Journal of the Florida Medical Association for December 1955, page 500.

A brief summary of the progress made at each of the State's two new medical schools was given at each meeting by Doctor Harrell, Dean of the School at the University of Florida and by Dr. Homer F. Marsh, Dean of the University of Miami School of Medicine. The state officers reported on various phases of the activities of the Association and Dr. Webster Merritt, assistant editor of the Journal, reported progress of the Journal at the meetings in Lakeland and Gainesville.

Present at all of the meetings, in addition to the officers, were Mr. Ernest Gibson and Mr. Harold Parham who aided greatly in the success of the meetings. Workshop sessions at each meeting for the ladies of the Women's Auxiliary were held under the leadership of their president, Mrs. Samuel S. Lombardo of Jacksonville. Dr. Russell B. Carson and Mr. H. A. Schroder gave reports regarding activities for the Florida Blue Cross-Blue Shield.

The dinners and social hours at the termination of each meeting were exceptionally enjoyable and the Council highly commends each local committee on arrangements for their great assistance to the success of the meetings. A total of 323 members of the Florida Medical Association and 59 visitors and guests registered for these meetings. Invitations for holding the 1956 Medical District Meetings were accepted from Tallahassee for the Northwest District, from Ocala for the Northeast District, from Tampa for the Southwest District and from West Palm Beach for the Southeast District.

Your Council is pleased to report that no unusual problems were faced during the past year. Only a very few minor difficulties had to come to the attention of the Council and these were handled satisfactorily on the local level by the District Councilor. I wish to commend those able Councilors for their splendid leadership and success in their respective districts and to thank them personally, and in behalf of the Association, for their fine assistance throughout the year, namely: William P. Hixon, Walter J. Baker, Charles L. Parks, Sr., Henry J. Babers, Jr., James R. Boulware, Jr., C. Frank Chunn, James R. Sory and Ralph S. Sappenfield.

Supplement

Your Council has investigated thoroughly the request of several doctors in Collier County to sever their affiliations with Lee-Charlotte-Collier-Hendry County Medical Society and to form a Collier County Medical Society. Nine doctors from Collier County, all members of Florida Medical Association, have individually requested the Council to recommend such a charter. The Lee-Charlotte-Collier-Hendry County Medical Society has officially approved such action.

At a meeting held in Miami Beach on May 14, 1956 your Council unanimously approved the request for a charter for a Collier County Medical Society and recommends to the House of Delegates that such a charter be granted.

Respectfully submitted,
Ralph W. Jack, *Chairman*

Dr. Orr: "The report of the Committee on Advisory to Selective Service for Physicians and Allied Specialists, presented by Dr. J. Rocher Chappell, Chairman, is approved but the Committee suggests that a committee of such importance must have information which would be of value to the members and requests that in the future a report be made.

"I move that this portion of the report be adopted."

Seconded by Dr. Russell B. Carson.

Motion carried.

Report of Committee on Advisory to Selective Service for Physicians and Allied Specialists

J. Rocher Chappell, *Chairman*

This Committee has no activities to report.

Respectfully submitted,
J. Rocher Chappell, *Chairman*

Dr. Orr: "In his presidential address, Dr. Milton recommended to the House of Delegates 'that we contribute an equal amount to each (medical) school in the state and the amount be set up in the budget annually, not to exceed $300 to each school' toward the expenses of sending delegates to the Student American Medical Association. This recommendation is approved by your reference committee No. 3.

"I move that this portion of the report be adopted."

Seconded by Dr. James N. Patterson.

Motion carried.

Dr. Orr: "The report of the Board of Governors, pages 33 to 37 in the Handbook, and its supplemental report, presented by Dr. John D. Milton, Chairman, is approved with the following amendments: In Item 3 of the Supplemental Report, second line, the word 'additional' is deleted, and after the word 'members,' the words 'of the Board' are added, so that Item 3 will read: 'The establishment of an Executive Committee of the Board to be composed of the president and four members of the Board, appointed by the President, subject to Board approval.'

"Several committee chairmen who contributed to this report merit special commendation: Drs. Robert E. Zellner and the Committee on Medical Economics for the group disability insurance program; Dr. Edward Jelks and the Committee on Housing for their contribution to the building of our permanent home; and again, to Dr. Jelks, as Liaison to the Board of Governors on Public Relations, for his excellent work, with special reference to the 'Guide for Cooperation between Physicians and Attorneys in Florida.'

"I move that this portion of the report as amended be adopted."

Seconded by Dr. Clyde O. Anderson.

Motion carried.

Report of Board of Governors

John D. Milton, *Chairman*

During the administrative year and prior to the publication of this report, three meetings of the Board have been held: April 6, St. Petersburg; July 31, Jacksonville; November 27, Miami. A fourth meeting has been scheduled to be held before convening of the House of Delegates and will be covered in a supplemental report.

My deep gratitude is extended to the members of the Board who attended meetings at great personal sacrifice of time, convenience and money. The sincerity, thoroughness and wisdom with which they study and solve an astonishing variety of problems merits an expression of appreciation from every member of the Association.

Recommended By-Law Changes

Committee on Blood

Chapter VII—Sec. 21. BLOOD, Appointment and Duties—The Committee on Blood shall consist of five members. The President shall appoint four members, one from each medical district, one for one year, one for two years, one for three years and one for four years, and thereafter they shall be appointed for four years as the terms expire. The President shall also appoint each year one member at large for a term of one year. It is recommended that these include one representative each from the state and national blood bank associations. The President shall select the chairman of this committee. This committee shall act as an advisory to the local societies and also to the delegates to the American Medical Association, stress adequate blood collection and distribution in times of emergency, and maintain close cooperation with the Joint Blood Council in Washington. The committee shall keep the members of the Association informed of pertinent data on the subject of blood banks and their activities.

Change Sec. 21 to Sec. 23.

Chapter VII—Regular Committees

Sec. 1—line 23—Add after "Sec. 20" a semi-colon, and "a Committee on Blood (Section 21.)"

In line 25, change "Section 21" to "Section 23."

This amendment is submitted in accordance with a directive of the 1955 House of Delegates which instructed the Board to prepare the appropriate By-Law changes for submission to the 1956 House of Delegates.

Committee on Nursing

Chapter VII—Sec. 22. NURSING, Appointment and Duties—The Committee on Nursing shall consist of five members. The President shall appoint four members, one from each medical district, one for one year, one for two years, one for three years and one for four years, and thereafter they shall be appointed for four years as the terms expire. The President shall also appoint each year one member at large for a term of one year. The President shall select the chairman of this committee. This committee shall act as an advisory to state and local Professional Advisory Councils for Practical Nurses and the Professional Nurses' Association in problems dealing with all phases of nursing. The committee shall be the liaison of the Association in dealing with nursing groups, and it shall keep the members of the Association informed of major problems and trends in nursing and nursing education.

Change Sec. 22 to Sec. 24.

Chapter VII—Regular Committees

Sec. 1—line 23—Add after "a Committee on Blood (Sec. 21) "a semi-colon, and "a Committee on Nursing (Section 22.)"

In line 28, change "Section 22" to "Section 24."

This By-Law change was also directed by the 1955 House of Delegates.

As directed, your President made the required temporary appointments to each of these committees in order that each be able to function during the current year. Appointments as directed in the By-Law changes will be the responsibility of the incoming president.

Recommendations For Annual Meeting Sites

1957 — Hollywood Beach Hotel

After thorough consideration of all known avail-

able facilities within the state your Board recommends that the Hollywood Beach Hotel be designated as the site of the 1957 Annual Meeting.

1958 — Jacksonville

In accordance with a Constitutional Amendment, duly ratified by the required three-quarters of the county medical societies, which permits setting convention sites more than one year in advance, your Board recommends Jacksonville as the site for the 1958 Convention.

This recommendation is qualified to the extent that selection of this site is contingent upon completion of an assured addition to the George Washington Hotel and other additional hotel facilities now in the planning stage.

The By-Laws provide that the Board of Governors set the dates for these meetings. Your Board wishes to call to your attention that the only 1957 dates available to us at the Hollywood Beach are May 5-8. We have been advised we may yet have any dates desired for 1958 in Jacksonville.

Your Board, at the April 6 meeting, considered available dates submitted by the Hotel Fontainebleau and selected May 13-16 for the 1956 Annual Meeting.

Number one project for the year has been the completion of plans and the beginning of construction of a new permanent home for the Association, as authorized by the 1955 House of Delegates. A beautiful new building of contemporary design, adequate to carry on Association business now and in the forseeable future, is under construction on Riverside Avenue, Jacksonville. This activity will be covered in greater detail in a supplemental report.

An operating budget for the fiscal year beginning March 20, 1955, in amount of $132,680 was approved as presented by Dr. Samuel M. Day, Secretary-Treasurer. This budget is based upon past experience as reflected in the audited joint financial statement of the Secretary-Treasurer and Managing Director and published in the June 1955 Journal. It is anticipated that the financial statement for 1956 will be published in the July Journal.

In response to a request from Dean Homer F. Marsh of the University of Miami School of Medicine, three Association members were appointed to serve on a Preceptor Committee with representatives of the Florida Academy of General Practice and from the University. The function of the committee being to select preceptors from throughout the state to whom advance medical students would be assigned. Representing the Association on this committee are Drs. Walter C. Payne Sr., Edward Jelks and Robert J. Needles.

Three special committees have continued previously inaugurated studies:

1. Means and methods of implementing a loan fund to assist medical students; and to recommend an appropriate memorial to the late Dr. Stewart Thompson — Dr. Walter C. Jones, Chairman
2. Membership classification and standardization of nomenclature as requested by the A.M.A.—Dr. Russell B. Carson, Chairman
3. Consideration of reimbursement to association officers, members of the Board of Governors and other association representatives for certain expenses incurred in carrying out their assignments—Dr. Russell B. Carson, Chairman

A request from the Florida State Dental Society for approval of fluoridation of public water supplies was referred to the Committee on Tuberculosis and Public Health.

At the request of the Board of Directors of Blue Shield of Florida, Inc., your Board of Governors agreed to waive Board approval of such nominations for members of the Board of Directors as made from the floor at Blue Shield's annual meeting. The Board of Governors still passes on those nominations to the Blue Shield Board as submitted by its nominating committee.

In order to attempt to resolve differences of opinion relating to contemplated legislation on physical therapy a committee was appointed to study the subject and to submit recommendations well in advance of the 1957 legislature. Your Board designated that this committee be comprised of two orthopedic physicians, one physician actively engaged in physical medicine, one member of the FMA Committee on Legislation and Public Policy, and to request the Florida Hospital Association to appoint one member. The members of this committee are: Drs. Homer L. Pearson Jr., Chairman, Edward W. Cullipher, Herschel G. Cole, Kenneth Phillips, Edward Jelks and Mr. Donald M. Schroder.

A new fee schedule as submitted by the State Welfare Board was approved as follows:

1. The fee for permanent and total disability medical examinations for the State Welfare Board shall be $7.50 which would include urinalysis and hemoglobin.
2. Where special laboratory work is required, the fee of $10.00 will be allowed, but authorization from the Welfare Board must first be obtained.
3. Consultation fees shall be $15.00, $20.00 and $25.00, depending upon the individual case, and authorization must be obtained.

Three hundred dollars was appropriated to assist the University of Miami School of Medicine Chapter of the Student American Medical Association send delegates to the national meeting of this association.

On recommendation from their county medical societies, the following members were transferred to Honorary classification: Laurin L. Andrews, Mark McCulloh Byrd, Noah T. County, Frederick J. Fox, Chas. W. Larrabee and Joseph E. Rose.

By virtue of having held membership in the Association for 35 years, the following became eligible for Life Membership Classification: Walter J. Baker, Grady H. Brantley, Francis A. Copp, George M. Dawson, Gordon F. Henry, Frederick C. Keisling, Robert B. McIver, J. William Martin, Robert L. Miller, Clarence D. Rollins, E. Thomas Sellers, Herman Watson and Albert H. Wilkinson.

Following presentation of reasons deemed adequate, accompanied by recommendation from their county medical societies, four members were excused from payment of dues. These are in addition to 30 members in military service whose dues are automatically credited for their period of obligatory service.

Your Board carefully considered and approved, with commendation, the schedule and program for the Eighty-Second Annual Meeting, as submitted by Dr. Donald F. Marion, Chairman, Scientific Work Committee. This schedule as published in the April Journal, and as contained in the official programs reverts to the system used prior to the 1955 meeting of holding all specialty group meetings on Saturday and Sunday immediately preceding the Annual Meeting.

All directives of the 1955 House of Delegates contained in approved resolutions, reports of committee chairmen, or other official action, have been complied with to the best of the Board's considered judgment.

Sub-Committee to Board of Governors on Veterans' Care

During the past year $363,214.00 have been paid to members of the Florida Medical Association for care of veterans.

Dr. George Stubbs has made talks on the necessity of getting the Veterans Administration to stop treating non-service connected cases before the St. Johns, Leon-Gadsden-Liberty-Wakulla-Jefferson, Jackson-Calhoun and Bay county medical societies and he arranged for a talk to be given to the Franklin-Gulf County Medical Society at Apalachicola. Your chairman gave talks before the medical societies of all the remaining counties in the northeastern district. Talks have also been given before many of the county societies in the southern areas of the state. We need volunteers to make these talks in the southern areas of the state.

Work is progressing on a booklet telling of the veterans' care program and including a copy of the fee schedule and agreement between the Florida Medical Association and the Veterans Administration. This

booklet will be distributed to the membership of the Florida Medical Association in the near future.

Frederick H. Bowen, Chairman

Sub-Committee to Board of Governors on Blue Shield

Immediately following the annual meeting of the Florida Medical Association in St. Petersburg, April 3-5, 1955, the first meeting of the newly constituted active membership of Blue Shield was held in accordance with the 1954 revision of the Blue Shield Constitution. During the succeeding six months further revisions of the Charter and or By-Laws were studied, recommended and adopted. These revisions in brief were:

1. The elimination of proxies.
2. Provision allowing nominations for Directors to be made from the floor by Active Members at the annual meeting — nominations from the floor to be in addition to nominations submitted by a nominating committee. Present requirement that nominations be approved by the Board of Governors of the Florida Medical Association will not apply to nominations from the floor.
3. A clearer definition of Active Members.
4. A provision for the removal of directors for non-attendance at meetings.
5. Increase in quorum for Active Members to 30 members.
6. Increase in Board of Directors to 19 members so that Executive Director may be a member of the Board on a permanent basis.
7. Provision for regular quarterly meetings of the Board, the dates of the meetings to be fixed by the Board.

These revisions have been approved (November, 1955) by the State Insurance Commissioner and by the Circuit Judge of Duval County.

During the past two years the Board of Directors of Blue Shield and a Special Committee from the Board studied the problem of new or additional contracts including those of deductible type, disaster or catastrophic illness type, medical coverage type, increased benefit type and preferred income type. The Contract Committee reported the results of this study to the Board of Directors at its July 30, 1955, meeting and recommended a new and additional Blue Shield contract with a new schedule of benefits and new income level and voted that the new contract be presented to the medical profession of the state through meetings with the county societies. The presentation of the "P Contract" met with opposition from some county medical societies and with favor from others. However, lack of the full support of the Florida medical profession caused the Board of Directors of Blue Shield to suspend further consideration of this contract.

Blue Shield of Florida has had a successful year in its growth with an enrollment of 495,988 on December 31, 1955. Utilization of Blue Shield also increased from 82.4 percent in 1954 to 83.9 percent in 1955, a trend which if continued would necessitate an increase in premium or decrease in the benefits paid.

Russell B. Carson, Chairman

Supplement

This supplement to the Report of the Board of Governors is in addition to, and a part of, the original report as printed in the Handbook. It is submitted to include a meeting of the Board in Jacksonville on April 8.

Your Board after careful consideration approved:

1. Two nominees for each vacancy on the Blue Shield Board of Directors for presentation to the active members of Blue Shield at its annual meeting on May 13, 1956. The slate from which these nominees were selected was presented to the Board of Governors by the Blue Shield Nominating Committee, Dr. Ralph S. Sappenfield, Chairman.
2. An operating budget submitted by Dr. Samuel M. Day, Secretary-Treasurer, for the fiscal year ending March 20, 1957, in the amount of $143,248. A copy of the budget will be mailed to any member of the Association on request.
3. The establishment of an executive committee of the Board to be comprised of the president and four members of the Board appointed by the president subject to Board approval.
4. The recommendation of the Committee on Medical Economics to establish a statewide group disability insurance program as designed by the insurance brokerage firm of Marsh & McLennan and to be underwritten by Continental Casualty Co.; and to recommend to the House of Delegates that this program be made available to the membership. Members interested in this proposal are urged to be present when it is considered by Reference Committee No. 3, Finance and Administration. This committee meets in the North Card Room at 2:30 p.m. today.
5. The report of the Special Committee on Physical Therapy, Dr. Homer L. Pearson Jr., Chairman. Copies of this report may be requested from Dr. Pearson or Dr. H. Phillip Hampton, Chairman, Committee on Legislation and Public Policy.

Sub-Committee on Housing

Following authorization by the Board of Governors, your Committee reviewed all property available for purchase that was considered desirable for the location of a permanent home for the Association, and purchased the property located at 735 Riverside Avenue. This property adjoins the expressway system in the Riverside Section of Jacksonville. Lot size is 100 ft. on Riverside Avenue and 222 ft. deep, running back to Standish Place. The north line of the property adjoins the State Road Department right of way. The purchase price was $35,000.00. The property was successfully rezoned to Business AA, which resulted in an increase in the value of the property.

Your Committee believed an architectural firm well known throughout the state of Florida and one known to members of the Committee from previous architectural contact should be chosen. The firm of Saxelbye and Powell, Architects, Jacksonville, met these qualifications and was selected.

Mr. Saxelbye was instructed to study the present operations of the Association's executive office, inspect the present office space to determine the needs of the Association and prepare preliminary plans and specifications. He was authorized to obtain the necessary engineer's survey and borings of the property.

Bids were let for the removal of the house from the property and the bid was awarded to Earl C. Bryson Wrecking Company for removal of the Structures from the property for a sum of $150.00 net to be paid to the Association.

The preliminary plans and specifications were presented to the Committee by Mr. Saxelbye in June. The Committee instructed Mr. Saxelbye to make certain changes to cut the cost of the building which would not lower the function or quality of the building. The architect was also instructed not to exceed approximately 6,000 square feet. He was further instructed to complete the final plans and specifications, and to let them out for bids to contractors in Florida, subject to the approval of the Committee.

The bids were opened in November and they ranged from $115,895.00 to $133,662.00. The low bidder was Gallespie Construction Company of Jacksonville.

The architect was instructed to review the plans and specifications and draw up a list of every reasonable item which could be eliminated or changed to reduce the construction cost and to confer with the lowest bidder to determine the amount to be saved by each item.

The plans and specifications and bids were presented to the Board of Governors with the alternate proposal of items which could be eliminated.

Upon authorization of the Board of Governors, the Committee awarded the contract to Gallespie Construction Company (with specific changes) for the amount of $114,870.00.

At the Board's request, your Committee arranged with the Atlantic National Bank of Jacksonville to borrow up to $25,000.00 at an interest rate of 4½% per annum, unsecured, in the event it was needed to complete the building program.

The contractor obtained security bond and a building permit and began construction of the building in December. The contemplated time of completion is June, 1956.

Your Committee is convinced that the construction of a permanent home will result in a financial saving to the Association in addition to all the advantages of ownership. This is based upon the cost of the property, building, architect's fees, depreciation over a period of 33 years, loss of interest on invested money at 4% per year, and estimates for insurance, taxes, utilities, maintenance and janitorial services.

Comparative Cost per Square Foot:

A. Our Building—$2.41 per square foot per year.

B. Rent in Jacksonville Area—Average $3.90 per square foot yer pear.

C. Present Rent—$3.00 per square foot per year.

The six thousand square feet in our building (based on our estimates) will be only 61% of the cost to rent comparable space elsewhere in Jacksonville.

Our Building

Property	$ 35,000.00
Building	114,870.00
Architect's fee	6,892.00
	$156,762.00

Depreciation (33 years)—building and architect	$ 3,690.00	per year
Less Interest on invested money @ 4%	6,270.00	1st year
Taxes	00.00	per year
Insurance	500.00	per year
Utilities (estimated)	1,800.00	per year
Maintenance and janitorial service (estimated)	2,200.00	per year
	$14,460.00	per year

$14,460.00 ÷ 6,000 square feet = $2.41 per square foot per year — PLUS ownership advantages and parking area

Your Committee wishes to express our appreciation to our officers, members of the Board of Governors and executive staff for their assistance in making our permanent home a reality.

Edward Jelks, *Chairman*

Liaison to Board of Governors on Public Relations

Your liaison officer's primary activity has been in promoting the principles contained in the long range public relations program which was adopted by the House of Delegates in 1954. This program has been re-evaluated this year and is believed to be currently sound. No changes, therefore, are recommended, but rather continued effort on its implementation.

Great effort has been made by your public relations supervisor and me to attend county medical society meetings and to visit the county medical society officers and committee chairmen. We have endeavored to apprise them of our program, the need for it, the policies and procedures involved, the activities of other county medical societies and the current problems the Association's committees and Board are studying. Also, we have sought to obtain their views and suggestions and to acquaint them with the assistance available to them from the Association's executive office.

Our Public Relations Advisory Committee has been revised this year. Two members have been requested to serve another year and continue with their present projects: Francis T. Holland, Tallahassee—rural health and W. Tracy Haverfield, Miami—liaison with other professional groups. Four new members have been requested to serve with the following assignments: Floyd K. Hurt, Jacksonville—payment for medical care; N. Worth Gables, St. Petersburg—medical forums, newspaper articles, speakers bureaus, radio and TV programs; Robert L. Tolle, Orlando—guarantee of medical care for all.

A guide to establish close cooperation between physicians and attorneys in Florida has been prepared by W. Tracy Haverfield, representing our Association, and the Professional Relations Committee of the Florida Bar. This guide is attached as Appendix 1, and the Board's approval of the principles stated therein is respectfully requested.

In response to the requests from members of the Association, a pamphlet has been prepared, and approved by the Board, entitled "Protection Against the Expenses of Illness and Accidents Is Smart Protection." This brochure outlines the various types of health insurance coverage and what to obtain when purchasing health insurance. It is presented in the name of the Association, and the cost is being defrayed by Blue Shield of Florida, incorporated.

Use of health and medical films by TV stations and the number of radio stations broadcasting transcribed health education series have increased during the year. Efforts have been made to keep interested stations active by acquainting them with new programs and by requesting comments and suggestions. All of these activities have been coordinated with those of the county medical societies.

A conference of key representatives of participating organizations in the rural health program was sponsored by the Association and held in September in Jacksonville. This conference was designed to assist in evaluating the rural health program and to make recommendations for future activities in this field.

Emphasis has been placed on coordination with the Woman's Auxiliary, allied groups, independent and government agencies, and liaison between the American Medical Association and other state medical associations, committees of our Association and county medical societies.

I am pleased to report that great progress is being made by the county medical societies from an organizational standpoint and with medical public relations. The further development of projects and expansion of the program in new areas is on the increase by the societies in every area of the state.

I wish to express my appreciation to the officers of the Association, the Board of Governors, the Public Relations Advisory Committee, chairmen of the various standing and special committees, the individual members of the Association and the staff of the executive office for their assistance and cooperation in helping to make Florida a state of better medical public relations.

Edward Jelks

A Guide to Establish Close Cooperation Between Physicians and Attorneys in Florida, 1956

Sponsored by The Florida Bar, P.O. Box 1226, Tallahassee, Florida and Florida Medical Association, P.O. Box 1018, Jacksonville, Florida.

The guide to establish close cooperation among physicians and attorneys contained in this folder is intended to serve as a basic outline for County Medical Societies and local bar associations to follow in developing a program locally.

The Purpose

To establish close cooperation between the medical and legal professions in the interest of public welfare, justice, health and the practice of Law and Medicine in Florida.

The Program

1. Education—
   a. Interprofessional—(1) Promote an exchange of information and ideas between the medical and legal professions through Medico-Legal Institutes and speakers appearing on the programs of the other profession.

      (2) Establishment and continuation of a liaison committee on a state and local level between the two professions.

      (3) Development of personal, fraternal and social relationship between members of the two professions.

   b. Public—Promote the dissemination to the general public of information to create a better understanding of medico-legal problems.
2. Public Service—Joint sponsorship of programs to guarantee assistance to those in need of medico-legal assistance.
3. Legislation—Joint sponsorship of legislation of mutual interest to the medical and legal professions to improve the welfare of the general public.
4. Medico-Legal Jurisprudence—
   a. Medico-Legal Examiners System—Promote the establishment and continuation of a state-wide, uniform medico-legal examiners' system in Florida.
   b. Personal Injury Litigation—Promotion of guides on a local level to encourage an agreement and standardization of practice governing lawyers and physicians in cases involving medical testimony.
   c. Professional Liability Litigation—Promote an understanding between the two professions of the problems and trends of professional liability suits in Florida.

Your Chairman wishes to take this opportunity to express personal appreciation to the members of the Board for their excellent cooperation and for the careful consideration with which they have weighed matters which have come to the attention of the Board.

Respectfully submitted,
John D. Milton, *Chairman*

Dr. Orr: "The Report of the Committee on Emergency Medical Service, presented by Dr. Rowland E. Wood, Chairman, is approved with the following amendment: That after item 6, add the following. '7. That the committee cooperate closely with the new Committee on Blood.'

"I move that this portion of the report as amended be adopted."

Motion seconded and carried.

Report of Committee on Emergency Medical Service

Rowland E. Wood, *Chairman*

This committee offers the following program for consideration by the Florida Medical Association with the idea that it should be the guide for the Emergency Medical Service Committees of the component societies:

1. Develop a working plan for the duties and location of work for doctors and allied professions in any type of disaster.
2. Make a survey of available buildings and designation of same to care for patients in the event of a disaster. It is to be recognized that the existing hospitals will not be adequate in the event of a major disaster.
3. Develop a plan for evacuation of surplus casualties to adjacent areas if needed.
4. Contact and cooperate with the Federal Civil Defense Administration and the Red Cross in the development of their plans.
5. Develop a plan to send teams of physicians to other areas if needed.
6. Make a survey of medical supplies available in the area needed in case of a disaster. This should include hospitals, pharmacists, wholesale drug houses, Red Cross and Federal Civil Defense Administration.
7. That the committee cooperate closely with the new Committee on Blood.

It is to be understood that the Florida Medical Association and its component societies, under the present Florida Plan, are responsible for the professional services in a disaster. Your committee believes that the most likely medical disasters affecting this state are: hotel fires, hurricanes, nuclear explosions.

It is the belief of your committee that special recognition should be paid to the Dade County Medical Association. The emergency medical service set-up in Dade county is one of the finest in the nation and certainly the finest in the southeastern area.

Your committee transmitted Resolution No. 21 on Automotive Safety (J.A.M.A., pp. 845-846) to Mr. Eugene V. Fisher, Motor Vehicle Commission of the State of Florida on September 8, 1955. As of this writing no reply has been received.

Respectfully submitted,
Rowland E. Wood, *Chairman*

Dr. Orr: "The resolution on Uniform Insurance Forms, presented by the Broward County Medical Association, is approved.

"I move that this portion of the report be adopted."

Seconded by Dr. Cecil M. Peek.

Motion carried.

Resolution
Insurance Forms

WHEREAS, there are many insurance companies with a multiplicity of forms doing business in the state of Florida and

WHEREAS, essentially the same information is solicited by each company:

BE IT THEREFORE RESOLVED, that the Florida Medical Association appoint a committee to work with a similar committee of the Florida Hospital Association to effect a standard information form for all insurance companies.

Respectfully submitted,
Burns A. Dobbins Jr.
Chairman of Delegates
Broward County Medical Association

Dr. Orr: "I would like to move for adoption of the report as a whole."

Seconded by Dr. Herbert L. Bryans.

Motion carried.

Dr. Orr. "I would also like to thank the members of the committee for their counsel and assistance."

Dr. Milton called attention to the fact that it was 12:00 noon, and asked whether the House wished to hold the election of officers at this time, or finish the reports first.

Dr. Dobbins: I move that the clock be stopped.

Motion seconded and carried.

Dr. Milton: "In approving the report of the Board of Governors, you have approved the group disability insurance program. You will receive a letter from the insurance people and I would suggest that you answer it as soon as possible, as the success of this plan is dependent upon 60 per cent participation.

Dr. Zellner: "I would like to ask the delegates to tell their county society secretaries that it will be appreciated if they will grant time on the program for these people. They will all be contacted."

Report of Reference Committee No. 4

Dr. Edward R. Annis, Chairman of Reference Committee No. 4, Legislation, was recognized and asked to give his report.

Dr. Annis: "From time to time, many of you have attended medical meetings too close home. I was unable to attend the committee meeting yesterday for that reason. Dr. Phillip Hampton took over as chairman.

"The report of the Committee on Legislation and Public Policy, presented by Dr. H. Phillip Hampton, Chairman, is approved as published in the Handbook.

"I move the report be adopted."

Seconded by Dr. Warren W. Quillian.

Motion carried.

Report of Committee on Legislation and Public Policy

H. Phillip Hampton, *Chairman*

Your Committee has been active constantly during the past year in an attempt to assume the responsibilities placed upon us to represent the Association in promoting, securing and maintaining legislation in the best interest of public health and scientific medicine.

National Legislation

Close attention was given to our national legislative program and requests from the AMA Committee on Legislation and the AMA Washington Office to assist with specific legislation were complied with. We are very fortunate to have among us in Florida, Reuben B. Chrisman Jr., M.D., of Miami, a member of the AMA Committee on Legislation, whose broad knowledge of medical legislation and generous assistance has been of great value.

Our key contact physicians in Florida for national legislation should also be complimented for their prompt action when called upon for assistance. They are Drs. Samuel M. Day, Francis T. Holland, Richard F. Stover, Duncan T. McEwan, Cecil M. Peek, Reaves A. Wilson, and John E. Maines Jr.

State Legislation

Prior to the 1955 Session of the Florida Legislature, your Committee studied all proposed legislation received from county medical societies, referred by the Association's officers, requested by the House of Delegates, referred by allied organizations and referred by state officials. This proposed legislation was presented with recommendations and a definite program was adopted by the Pre-Legislative Joint Conference of the Board of Governors, House of Delegates, Bureau of Public Relations and Committee on Legislation and Public Policy on November 29, 1954 in Miami.

A copy of the proposed legislation was forwarded to each county medical society with a Legislator Interview Report. The county medical societies were requested to discuss this legislation with their legislators and return the report to our Committee. Twenty-seven of the thirty-six county medical societies complied with this request.

Your Committee is pleased to report that four of the six bills sponsored by the Association passed and became law. They are:

1. Hospital Service for the Indigent. This law established state funds to match county funds for hospitalization of acutely ill indigent persons and carried out the recommendations of the Committee on Indigent Hospitalization appointed by Governor LeRoy Collins at the request of the Florida Medical Association. This bill was also part of the Governor's legislative program.

2. Amendments to Medical Practice Act. This bill eliminated the section of the law which instructed the Board of Medical Examiners to examine graduates of schools of medicine, other than those approved by the Board, who had received subsequent post-graduate training, in the opinion of the Board, to bring their education up to a standard equivalent to that of graduates of approved medical schools and colleges.

It amended the subjects to be examined in by changing pathology to surgical pathology, and anatomy to applied anatomy, added pediatrics and eliminated physiology and chemistry. It removed the requirement for unlicensed physicians employed by a licensed physician to register with the State Board of Health and removed any implied authority for an unlicensed physician to be employed by a licensed physician. It accomplished statuatory revisions which clarified and corrected certain inconsistencies. This bill was cosponsored by the Board of Medical Examiners.

3. Registration Act. This law requires every practitioner of the healing arts to register with the State Board of Health, the first registration to be under oath, and requires the registrant to state the number of his license, college from which he graduated, and the date.

4. Tax Exemption for Real Estate Owned by Medical Societies. This bill amended the Florida Statutes relating to property exempt from taxation by adding a new sub-section which provides that certain real estate of medical societies be exempt.

The two bills which failed to pass are:

1. Healing Art Identification Act. This bill demanded that every practitioner of the healing arts designate the kind, branch, and system of the healing art he is licensed to practice in professional use of his name. It required every clinic or hospital to designate the kind or system of healing art practiced therein with the exception of medical hospitals and clinics.

This bill was strongly opposed by other branches of the healing art.

2. Clinic Bill. This bill defines the word "Clinic" as three or more duly licensed physicians associated together for the practice of their profession and prohibits any others from using the word "clinic". The bill required the branch of the healing art practiced to be designated in the clinic name. This bill did not have the support of legislators from smaller counties, where physicians were not in favor of this legislation.

An unfortunate controversy lasted for several weeks during the session in Tallahassee over a bill to amend the Grandfather Clause of the Registered Physical Therapy Law which required us to postpone hearings on our legislation before the public health committees in the House and Senate. This controversy was undoubtedly responsible for the failure of our Healing Art Identification Act to pass the House after it had passed the Senate, and also jeopardized other legislation we were sponsoring.

Our Association was influential in the passage of legislation sponsored by others and also responsible for the defeat of a great deal of undesirable health legislation.

To carry out this program, many meetings and conferences were held, personal contacts were made and communications written and many other activities too voluminous to include in this report.

An office was maintained in Tallahassee during the entire Session by Mr. Harold Parham, of the executive office, and legal counsel available from the attorney retained by the Association, Mr. Ben C. Willis. Your Chairman was present in Tallahassee for committee hearings and other activities when necessary.

Your Committee desires to emphasize that the success of our program this year was due primarily to the work done by the county medical societies prior to the legislative session and during the session when called upon for assistance.

Emphasis during the past year has also been placed upon closer liaison with state officers, agencies, departments and commissions in Florida to provide medical guidance and counsel on matters pertaining to health.

On behalf of the Committee, I desire to express our deep appreciation for the assistance rendered by our president, John Milton, our secretary, Sam Day, Edward Jelks, Public Relations Liaison to the Board of Governors, Eugene G. Peck Sr., the former chairman of our Committee, members of the Board of Governors, members of the Association's executive staff, officers and individual members of the county medical societies who have responded when called on for assistance.

Commendation by the House of Delegates is highly recommended for Harold Parham for his outstanding work and assistance to our Commitee and the physicians of Florida toward accomplishing our desired goals.

Respectfully submitted,
H. Phillip Hampton, *Chairman*

Dr. Annis: "I would like to take this opportunity to call to your attention the very fortunate climate which will exist in Tallahassee for the next five years in the field of legislation and public policy, not only because of the major action at the polls, but also in not returning to the Legislature some of those who have been obstructionists and have opposed the medical association for many years."

"Next, the resolution on study of Driver Licensing Law, presented by the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, is approved as printed in the Handbook.

"I move the resolution be adopted."

Motion seconded and carried.

Resolution
Study of Driver Licensing Law

WHEREAS, the Department of Public Safety of the State of Florida is anxious to safeguard at all times all lives in the issuing of licenses.

WHEREAS, though Florida has the Uniform Driver Act as to who should be and who should not be issued licenses, there has not been a clear-cut definition of certain borderline cases.

WHEREAS, the Department of Public Safety has asked the Leon - Gadsden - Liberty - Wakulla - Jefferson County Medical Society to appoint a committee to review certain applications prior to issuing licenses.

WHEREAS, the Leon et al County Medical Society does not feel that since this is a state-wide project, it should be a county society responsibility.

NOW, THEREFORE BE IT RESOLVED that the Florida Medical Association appoint a committee to act and to work in cooperation with the Department of Public Safety in the issuance of driver's licenses, and also to study the present law and the laws of other states in order that the state of Florida may have a better driver's license law.

It is recommended by the Department of Public Safety that the chairman of this committee be a resident of Tallahassee.

Respectfully submitted,
Odis G. Kendrick Jr., Secretary
Leon-Gadsden-Liberty-Wakulla-
Jefferson County Medical Society

Dr. Annis: "The resolution on Advertising by Members of the Healing Arts, presented by Dr. Franklin J. Evans of Dade County, is approved with the following amendments: That the resolution be amended to read: 'That the legislative committee be instructed to study the problem and devise means which will prohibit improper and misleading advertising by any licensed member of the Healing Arts in the State of Florida.

"I move the resolution be adopted as amended."

Motion seconded and carried.

Resolution
Advertising by Members of the Healing Arts

WHEREAS, certain members of the Healing Arts have openly advertised in the newspapers, on radio and television; and

WHEREAS, the Florida Medical Association believes that such advertising is detrimental to the general public and lowers the professional standards of all members of the Healing Arts; and

WHEREAS, the Florida Medical Association is opposed to any advertising of an individual public nature by any member of the Healing Arts;

BE IT THEREFORE RESOLVED, that the legislative committee be instructed to study the problem and devise means which will prohibit improper and misleading advertising by any licensed member of the Healing Arts in the State of Florida.

Respectfully submitted,
Franklin J. Evans

Dr. Annis: "That portion of the Board of Governors' report, presented by Dr. John D. Milton, Chairman, regarding Indigent Medical Care

and Florida medical foundation, is approved with the following amendments: Item 2 be amended to read — 'The establishment of a Florida medical foundation to be controlled and administered by the Florida Medical Association, the purpose of which is to promote better medical care in Florida, and the Board of Governors be directed to take the necessary steps to establish the Florida medical foundation.' Item 4 be amended to read — 'Authorize the Chairman of the Committee on Legislation and Public Policy to explore the possibility of contributions to a Florida medical foundation.' Item 5 to be deleted.

"I move the report as amended be adopted."

Seconded by Dr. Cecil M. Peek.

Indigent Medical Care and Florida Medical Foundation

Your Board of Governors, after careful consideration, approved a special report of the Committee on Legislation and Public Policy, Dr. H. Phillip Hampton, Chairman, pertaining to indigent medical care in Florida and the establishment of a Florida medical foundation, and request the House of Delegates to approve the following recommendations:

1. Approve the "Hospital Service for the Indigent" program in Florida (Chapter 401, Florida Statutes 1955), which became effective January 1, 1956.
2. The establishment of a Florida medical foundation to be controlled and administered by the Florida Medical Association, the purpose of which is to promote better medical care in Florida, and the Board of Governors be directed to take the necessary steps to establish the Florida medical foundation.
3. Approve the Board of Governors' request in the name of the Florida Medical Association, for a grant from the U. S. Public Health Service for a demonstration pilot study of coordinating hospital service for the indigent with better hospital utilization, postgraduate medical education, out-patient care for the indigent and improved quality of medical hospital care.
4. Authorize the Chairman of the Committee on Legislation and Public Policy to explore the possibility of contributions to a Florida medical foundation.

Due to the nature of this proposal this portion of the Supplement to the Report of the Board of Governors is being referred to Reference Committee No. 4, Legislation.

Respectfully submitted,
John D. Milton, *Chairman*

Dr. W. Dean Steward: "I rise to a point of order — the title 'Florida Medical Foundation' was disapproved by the committee. These words are to be in small letters with the understanding that the name of the foundation has not been designated."

Dr. Annis: "That is correct. That is the way it is shown in the amended version."

Dr. H. Phillip Hampton: "The hospital service for the indigent program, which is now a law, was passed on recommendation of Governor Collins' study committee which was recommended to him by the House of Delegates. This law was written following those recommendations. Now, we are asking that you approve the law. For complete information about how it works, I would refer you to Florida Health Notes for May, 1956. This is the publication of the Florida State Board of Health."

"I would like to explore the possibilities of contributions from the State Welfare Board to the foundation."

Dr. Chas. J. Collins: "I do not understand, Dr. Hampton. Are you going to solicit funds from the State Welfare Board for our medical services to the indigent? Is that correct, Dr. Hampton?

Dr. Hampton. "I did not say that I would solicit funds — I would like to explore the possibility of contributions to the foundation from this agency."

Dr. Collins: "On what basis? It was my understanding that this part of the report was to be deleted, that we would not accept any funds whatsoever from the State Welfare Board for our services to medically indigent patients. I don't care whether it is paid to you or to the medical foundation, I think it is a mistake. I think we should continue to donate our services."

Dr. W. Dean Steward: "I want to emphasize what Dr. Collins has said. I was there and considerable discussion was held and it was finally decided, at least it was my understanding, that the last paragraph would be deleted, which made mention of payment. It was our feeling that indigent care has always been a free service and should continue to be so. It was our understanding that it would not be brought up."

Dr. Annis: "In the recommendations of the committee, the paragraph referred to was deleted. We are not acting on that portion of the report."

Motion carried.

Dr. Annis: "Before leaving the platform, may I remind you of the yeoman service performed by Dr. Hampton for us. He has worked throughout the year and ingratiated himself with members of the Senate and House. He is well received in all administrative circles in Tallahassee and because of the favorable climate in Tallahassee, perhaps for the first time in many years the Florida Medical Association will at last be heard. Not a little of our favorable position at the present time is due to the work of Dr. Eugene G. Peek Sr., of Ocala, and the man who followed him so well, Dr. Hampton."

Dr. Milton: "Last Saturday I had the pleasure of appearing before the Florida Bar. As you know, we have had a committee working with reference to better cooperation between the two professions. The Florida Bar adopted the Code of Cooperation and your reference committee and you have just approved this Code of Cooperation. In view of this, we asked the President of the Florida Bar to be present, and I would like him to say a few words to you — Mr. Lance Lazonby of Gainesville."

Mr. Lazonby: "Mr. President, Members of the House, Ladies and Gentlemen: I am most grateful for the opportunity and privilege of bringing you the greetings of approximately 7,000 lawyers and judges of Florida who comprise the Florida Bar.

"Dr. Milton, as he told you, appeared before our Annual Meeting on Saturday last and brought a message from the Florida Medical Association. I hope that you will not consider this just an exchange of amenities. I believe that the significance is far greater. Lawyers, and particularly trial lawyers, come in contact with all of the professions but I think perhaps they come in contact more and work closely more with the members of the medical profession. Our two professions have many problems in common. There are problems that you discuss every time you meet. There are problems that we also have. I suggest, however, that some of our problems are created by us in each profession in giving more attention to the privileges that have been extended to us rather than the responsibilities that go with them. Most of these problems that I refer to are problems within the professions and I will not go any further into them except to say that responsible members of our profession and your profession are giving them consideration and we know that they will be of mutual benefit.

"I dislike summarizations, but in view of the very few minutes I have, I would like to leave a thought with which I am sure you will concur. That is, that the big problem that we have, the deepest issue of our time is whether our people in this country can and will maintain a free society. To maintain a free society it is imperative that leadership be furnished by the learned professions, which require training in objective thinking. Notwithstanding the lofty aims and spirit of public service on which each of our professions is grounded, it is basic that the leadership it exerts can be effective only to the extent that society accepts that leadership, and that, gentlemen, is a point that we should keep in mind constantly. We have commenced a wonderful and interdependent relationship based on mutual need, but also on mutual responsibility to society and I have the feeling that in the future together we will accomplish a great deal.

"Thank you so much."

Dr. Milton: "I think this is the beginning of a new era as far as our two professions are concerned and I am sure there will be great cooperation."

The Chair recognized Dr. Duncan T. McEwan, Secretary of the Board of Past Presidents.

Dr. McEwan. "The Board of Past Presidents met and we have two short recommendations. The first is that all resolutions or committee reports be published or read before the House of Delegates before the meetings of the Reference Committees and that if there is not time for this, such reports or resolutions be rejected. I think you can see why that should be done. If they are not read, the members of the House do not have an opportunity to go before the reference committees to discuss them.

"I move that is be referred to the Board of Governors for action."

Seconded by Dr. Frank J. Pyle.

Motion carried.

Dr. McEwan: "The Board of Past Presidents also recommends that the Board of Governors study the matter of poor attendance at the scientific sessions and study means of remedying this situation.

"I move that this be referred to the Board of Governors."

Seconded by Dr. Herbert L. Bryans.

Motion carried.

Dr. Milton: "Is there any unfinished business?"

The Chair recognized Dr. Hunter B. Rogers, President, Dade County Medical Association.

Dr. Rogers: "Mr. Chairman, Members of the House, we of Dade County Medical Association at this time would like to express our recognition

To
John D. Milton, M.D.
one of our members
WE PAY HONOR
for his superior service and
generous contribution to the physicians
and other citizens of this State
as President of the
FLORIDA MEDICAL ASSOCIATION
His leadership long will be unsurpassed
Hunter B. Rogers, M.D.
President
Vincent P. Corso, M.D.
Secretary

and appreciation to Dr. Milton for the successful administration of his duties and we would like to add this scroll to his many other honors."

Dr. Rogers presented to Dr. Milton a scroll. (shown on page 60)

Dr. Milton: "Dr. Rogers and members of the delegation from Dade County, I have no words to express my feelings. It is beyond words. What I have done for the Florida Medical Association and for organized medicine as a whole has been a pleasure.

"Gentlemen, you can start your clocks running. It is now twelve o'clock. We will proceed with the election of officers of our Association. First, we will have nominations for the office of President-Elect."

Dr. David R. Murphey Jr.: Mr. President, Members of the House of Delegates:

It gives me great pleasure to place before you for your consideration a nominee for the office of President-Elect of the Florida Medical Association.

The presidency of this Association is the greatest honor which it is your privilege to bestow on an individual member. The President-Elect is the one who will assume titular head of the Association at the next annual meeting.

Presidency of the Florida Medical Association has never been, and is not now, a "thank you" for past assignments well done, but rather calls for a person of integrity, ideals, wisdom, vision and sufficient youthful vigor to administer the affairs of this Association. The office requires a working officer.

My task is easy, as my nominee has been a leader in the profession in this state for 23 years. His activities have been so continuous and numerous that it is difficult to present his qualifications within a reasonable time without deleting some of his important contributions to the progress and well-being of our profession.

Our colleague was born into the home of a physician on Oct. 19, 1905 at McWilliams, Ala., a small sawmill community in Wilcox County, the heart of the "Black Belt." This section of the state derives its name from the color of the soil and, contrary to the opinion of many, has no relationship to racial distribution.

He received his early education in Southern Alabama, graduating from the Dothan High School in 1923. It was impossible to imagine in the fall of 1923, when our paths first crossed as freshmen at the University of Alabama, that someday it would be my privilege to nominate him for such a high office. In 1927 the University bestowed upon him the degree of Bachelor of Science in Medicine. He then fulfilled the requirements for the degree of Doctor of Medicine at the University of Tennessee in 1930. His practical and postgraduate education was obtained at St. Johns Hospital, Tulsa, Okla., Memphis General and Baptist Hospitals, Memphis, Tenn., and the Cook County Graduate School of Medicine, Chicago.

In August of 1932 he came to Florida as a qualified physician, lacking only a license from the State Board of Medical Examiners, which he obtained in November. For the benefit of the Examining Board, during the four month interval he worked in the Panama City Hospital under Dr. James M. Nixon, without benefit of a temporary license, as a hospital helper.

His interest in organized medicine manifested itself immediately. His county society was not active in 1932. Upon contacting the Association offices in Jacksonville, he was informed that Bay County had been granted a charter previously. Instead of organizing his county society he reactivated it, an even more difficult task. Since its reactivation the interest of this component society has never waned. The state society was not long in recognizing his many attributes. His first assignment in state affairs was well suited to his character, both as a youthful premedical student and as a nominee for the Florida Medical Association's greatest honor — Advisory to the Woman's Auxiliary. Subsequently, he has served on many state committees, some of which are Medical Postgraduate Course, Representatives to Industrial Council and Necrology.

In addition, three presidents of this Association have seen fit to appoint him to the Council, and he served one term as Chairman. He is at present a member of the Committee on Medical Economics and the Board of Governors of the Florida Medical Association and is a director of the Blue Shield of Florida. He also is active on the Advisory Committee to the College of Medicine of the University of Florida in Gainesville.

Neither my nominee's talents nor his activities are limited to administrative and committee performances. He has appeared on the scientific program of this Association on six occasions.

There are ways of ascertaining one's interest in organizational and professional activities other than committee appointments. Probably the most valuable of these is one's attendance record at the Association's meetings. During his

(Continued on page 64)

ACHROMYCIN*

Tetracycline *Lederle*

in the treatment of

infections in surgery

The prevention and control of cellulitis, abscess formation, and generalized sepsis has become commonplace technique in surgery since ACHROMYCIN has been available. Leading investigators have documented such findings in the literature.

For example, Albertson and Trout[1] have reported successful results with tetracycline (ACHROMYCIN) in diverticulitis, gangrene of the gall bladder, tubo-ovarian abscess, and retropharyngeal abscess. Prigot and his associates[2] used tetracycline in successfully treating patients with subcutaneous abscesses, cellulitis, carbuncles, infected lacerations, and other conditions.

As a prophylactic and as a therapeutic, ACHROMYCIN has shown its great worth to surgeons, as well as to internists, obstetricians, and physicians in every branch of medicine. This modern antibiotic offers rapid diffusion and penetration, quick development of effective blood levels, prompt control over a wide range of organisms, minimal side effects. There are 21 dosage forms to suit every need, every patient, including

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ACHROMYCIN with STRESS FORMULA VITAMINS. Broad-range antibiotic action to fight infection; important vitamins to help speed normal recovery. In *dry-filled, sealed* capsules for rapid and complete absorption, elimination of aftertaste.

dry-filled sealed capsules

[1]Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

[2]Prigot, A.; Whitaker, J. C.; Shidlovsky, B. A., and Marmell, M.: *ibid*, pp. 603-607.

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ACHROMYCIN ACHROMYCIN

(Continued from page 61)

23 years of membership he has always represented his county medical society as its one and only delegate and failed to fulfil his assignment only twice, once because of urgent local professional duties and again when he was denied a military leave for this purpose.

He served his country in World War II with distinction from 1942 until 1946. On April 1, 1945, he landed with the ground forces on the beachhead at Okinawa and made the first color motion picture in history of "Up-Front" surgery, 1,000 yards behind the line. This film has received national and international recognition. Since its showing to this Association several years ago, it has been shown by request to the Interstate Postgraduate Medical Association of North America, in Cleveland, and the Section on General Practice of the American Medical Association at Atlantic City. In addition, the War Department borrowed this film as an aid in compiling a training film on "Up-Front" surgery.

In addition to holding membership in his county society and the Florida Medical Association, he is a member of the American Medical Association, the International College of Surgeons and the Southeast Surgical Congress. He is a founder fellow of the American Academy of Obstetrics and Gynecology and he obtained fellowship in the American College of Surgeons the hard way — by examination.

In spite of his long continuous interest in his profession and education, my nominee found time in the cool of the evening for an old Southern custom — romance. While still a medical student, he met, squired and courted Miss Mary Ann Caffee, the daughter of one of his father's medical school classmates. The success of his extracurricular activities culminated in marriage and a son, bearing his father's name and now serving his country with the Armed Forces in Europe.

In addition to being a conscientious physician, he has been a good citizen, taking an active interest in community affairs. He has been president of his local Kiwanis Club, Country Club, and Yacht Club. At present, he is a trustee of his local Methodist Church.

These activities were a great asset when he led the successful fight in his county to prevent the opening of the city hospital to irregular practitioners. This test case in the form of a county referendum was ordered by the state legislature and, if it had not been defeated, would have opened the doors of all tax-supported hospitals in Florida to such staff appointments, thus lowering our high standards of medical care.

In view of the qualifications described, I count it a privilege to nominate for President-Elect of the Florida Medical Association Dr. William C. Roberts of Panama City.

Dr. Joseph S. Stewart: "Mr. Chairman, Ladies and Gentlemen: By the authority of the Dade County Delegation, it is my pleasure to second the nomination of our distinguished colleague from Bay County. Dr. Roberts will bring us the attributes so beautifully described by my good friend Dave Murphey, but Bill will bring us more than these attributes. He will bring to us his own first lady, who will bring a charm and dignity and beauty that will grace our meetings as our own first lady. Thank you."

Dr. Chas. J. Collins: "I move that the privilege of the floor be extended to Dr. Meredith Mallory."

Seconded by Dr. Herbert L. Bryans.

Motion carried.

Dr. Mallory: "Mr. President, Members of the House: I am indeed very grateful for this opportunity you have accorded me. On behalf of the Orange County Medical Society, I would like to endorse the man whose name has been placed in nomination. I have worked with this man for many years and I know his ability. He has one attribute that all of our leaders need and that is common, ordinary, everyday, horse sense. He knows the problems that face this organization and he is willing to give the time and effort to solve them. I am sure that the future of Florida medicine will be in competent hands. It is not only a privilege but an honor for me to endorse the name of William C. Roberts for the office of President-Elect of the Florida Medical Association."

Dr. Russell B. Carson: "The selection of a leader and president of this great association is a grave and serious responsibility as we all know. It requires the selection of a dedicated individual. It gives me great pleasure as a delegate from the Broward County Medical Association to second the nomination of Dr. Roberts."

Dr. Walter C. Jones: "Mr. President, Members of the House of Delegates: I have not been delegated by anyone to say what I have to say. I come as an individual. I have worked with this boy for a long time. He was one of my active committee chairmen when I was your president. I know he will always do a good job. I would like

to second his nomination and also move that the nominations be closed and the secretary be instructed to cast a unanimous ballot for Dr. Roberts."

Seconded by Dr. Shaler Richardson.

Motion carried.

Dr. Milton announced that Dr. Roberts was elected, and asked Dr. Roberts if he would like to come down to say a few words.

Dr. Roberts: "President John, Members of the House of Delegates of the Florida Medical Association, other Members and Guests: You know I have watched a lot of presidents-elect come up to this rostrum. This is about the first time I have ever heard of a fellow, weak-kneed as he is, having to make it all the way by himself. You have bestowed upon me a great honor, and I don't know whether I will be able to fulfil it or not. One of the fellows who nominated me said something about my 'Pooky'. Who is running, 'Pooky' or me? If I can't do it, 'Pooky' can.

"I want to pause just a minute to tell you — when I was taking the examinations to be a regularly licensed physician in Florida, I was introduced to Dr. Gerry Holden, then President of the Florida Medical Association. We neophytes had great ideas and he told us that if we were fortunate enough to be granted licenses to practice in this state, we should join our county medical societies and be active and take an interest in the state organization. That's when I learned that Bay was chartered but wasn't doing anything about it. I want to take this opportunity to urge the younger members to get active in their county medical societies. If you are for something, be for it, and if you are against it, be against it. I appreciate this honor; I am flattered. I will do my dead level best to make you a good servant and I hope 'Pooky' will make you a good president."

Dr. Milton: "He does look weak-kneed. I think he needs to be escorted back. Cecil, will you and Jere help him back to his seat?

Dr. Milton asked for nominations for First Vice President.

Dr. Robert E. Zellner: "I don't think any of us wants to see anything happen to our president and president-elect, but if it should I would like to place in nomination a man who has done everything from the smallest to the largest job in this association. After approximately 40 years of practice, he is still one of the most active members. He is a man whose advice is sought by the members of Orange as well as by the members of the whole delegation here. He is a member of the Board of Governors, he has been a delegate to the A.M.A. from Florida and has done practically any job anyone asked him to do. I nominate Dr. Meredith Mallory."

Dr. James R. Boulware Jr. moved that nominations be closed.

Seconded by Dr. George W. Morse.

Motion carried.

The President asked for a voice vote.

Dr. Milton: "Dr. Mallory is our First Vice President. We will now have nominations for Second Vice President."

Dr. N. Worth Gable: "I would like to present to you the name of Dr. Kenneth A. Morris of Duval County. He is a past president of the Duval County Medical Society and director of Duval Medical Center. I present Dr. Kenneth Morris."

Dr. Sidney G. Kennedy Jr. moved that nominations be closed.

Seconded by Dr. Cecil M. Peek.

Motion carried.

The Chair asked for a voice vote.

Dr. Milton: "The ayes have it — Dr. Morris is our Second Vice President."

Dr. Edwin W. Brown of Palm Beach nominated Dr. Cecil M. Peek for Third Vice President.

Dr. Ralph Herz: "I move that nominations be closed and the Secretary be instructed to cast the ballot for Dr. Peek."

Seconded by Dr. Boulware.

Motion carried.

Dr. Milton: "We will now have nominations for Secretary-Treasurer. Jere that's your job."

Dr. Jere W. Annis: "I would like to nominate Dr. Sam Day for another year."

Dr. Francis T. Holland: "I move that nominations be closed and the President be instructed to cast unanimous ballot for Dr. Day."

Seconded by Dr. Boulware.

Motion carried.

The President asked for nominations for Editor of The Journal.

Dr. A. Judson Graves: "President John, Members of the House: I know we are all conscious of the fact that a lot of fine things come out of the headquarters in Jacksonville, not the least of which is our Journal, which is a fine scientific publication. I would like to nominate Dr. Shaler Richardson to succeed himself as Editor of The Journal."

Dr. Jere W. Annis: "I move that nominations

be closed and the Secretary cast a unanimous ballot for Dr. Richardson."

Motion seconded and carried.

Dr. Milton: "It is my pleasure, gentlemen, to have escorted to the Chair your new President, Dr. Francis Langley. I would like to ask Dr. Rowlett and Dr. Joe Stewart to escort him forward."

"Dr. Rowlett does not seem to be present, so I will ask Dr. Clyde Anderson to assist Dr. Stewart."

"Francis, it is quite an honor today to give you the gavel. I relinquish the gavel with some regret but I know you will use it with great dignity and dispatch and I wish you a most successful year."

Dr. Langley: "Thank you, John.

"I think you all heard what Bill said about weak knees. You cannot prepare yourself for a situation like this in advance. I just would like to say that I shall do the very best I can for the Florida Medical Association. What I can do will not be too important but with your help and support, which I know I will get, I shall try my very best to make this a good year for our Association. When things come up, please feel free to come to me. Anything I can do in your behalf is yours. I thank you most sincerely for this honor.

"One of the nicest things in recent years in my work with the Florida Medical Association has been the privilege of associating with Dr. John Milton. As you come to know him better, you will appreciate him more and more. I cannot express the admiration and affection which I have developed for this fine gentleman. John, it gives me more pleasure than I can say to extend to you this Past President's certificate for your service. It could not be more deserved by anyone.

"One learns by the difficulties of others — at least one should. You will remember John's tribulations last year. I made a point of inspecting him this morning and investigating the size of the hole in his lapel. If I fumble, it will not be John's fault, he has a fine buttonhole in which to place the past President's button."

Dr. Langley announced that the Board of Governors would meet immediately following adjournment of the House of Delegates in the Rosewood Room.

There being no further business, the House of Delegates adjourned, sine die, at 1:00 p.m.

SCIENTIFIC ASSEMBLIES

First Scientific Assembly

The first Scientific Assembly convened at 9:30 a.m., Monday, May 14, in the La Ronde Room, Hotel Fontainebleau, with Dr. Donald F. Marion of Miami presiding. The following papers were read and discussed:

"Research Plan for Florida's Permanently and Totally Disabled Indigents: Analysis of 1500 Cases," Turner Z. Cason, Jacksonville.

"The First Decade of Atomic Medicine," Shields Warren, Professor of Pathology, The Harvard Medical School; President, American Board of Pathology, Boston.

"Future of Mental Health in Florida," Wilson T. Sowder, Jacksonville, and William D. Rogers, Chattahoochee. Presented by Dr. Sowder.

"Intertrochanteric Fractures and Fractures of the Neck of the Femur," James J. Callahan, Professor of Bone and Joint Surgery, Stritch School of Medicine, Loyola University, Chicago.

"The Therapeutic Application of Ultrasound Energy; Results of a Broad Clinical Survey," Kenneth Phillips, Miami; Robert R. Harriss, Hollywood; Leigh F. Robinson, Fort Lauderdale, and Edward F. Carter Sr., Tampa. Presented by Dr. Carter.

"Electrophoresis in Clinical Medicine," Charles Catanzaro, Tampa.

Second Scientific Assembly

The second Scientific Assembly convened at 2:00 p.m., Monday, May 14, in the La Ronde Room, Hotel Fontainebleau, with Dr. Marion presiding. The following papers were read and discussed:

"Skin Problems Associated with Aging," Morris Waisman, Tampa.

"Ganglionic Blocking Agents in Treatment Hypertension," Morton M. Halpern, Coral Gables.

"The Management of Chronic Uremia," Warren Lindau, Coral Gables.

"Ulcerative Proctitis," Thomas E. McKell, Tampa.

"Vagal Arrhythmias in Succinycholine—Modified Electroshock Therapy," Henry R. Cooper, Fort Lauderdale.

"A Physiologic Approach to the Problem of Vascular Disease of the Brain," Peritz Scheinberg, Miami.

Third Scientific Assembly

The third Scientific Assembly convened at 2:00 p.m., Tuesday, May 15, in the La Ronde Room, Hotel Fontainebleau, with Dr. Scottie J. Wilson of Fort Lauderdale presiding. The following papers were read and discussed:

"Surgical Dysphagia," Martin G. Gould, Fort Pierce.

"Emergency Management of Acute Cranial Trauma," Albert J. Ehlert, Miami.

"A New Era of Therapy in Psychiatry," Lauren H. Smith, Physician-in-Chief and Administrator, The Institute, Pennsylvania Hospital, Philadelphia.

"Spontaneous Abortion: A Physician Speaks to His Patient," John J. Fisher, Jacksonville.

"Whiplash Injuries to Spine," Lyle W. Russell, Miami.

"Non-Penetrating Abdominal Trauma," John J. Farrell, Miami.

REGISTRATION

The registration for the Eighty-Second Annual Meeting at Miami Beach surpassed that of any previous Convention of the Association. The total number registered was 2,091. The registrants include 977 members of the Association, 187 visiting physicians, 122 other guests, 494 members and guests of the Woman's Auxiliary, 7 scientific exhibitors and 304 representatives of exhibiting firms. There were 23 other states and 3 foreign countries represented.

Registration List

Officers

John D. Milton, M.D., President ..... Miami
Francis H. Langley, M.D., Pres.-Elect ..... St. Petersburg
Thomas C. Kenaston, M.D., 1st Vice Pres. ..... Cocoa
Sidney G. Kennedy Jr., M.D., 2nd Vice-Pres. ..... Pensacola
Walter E. Murphree, M.D., 3rd Vice-Pres. ..... Gainesville
Samuel M. Day, M.D., Secy.-Treas. ..... Jacksonville
Shaler Richardson, M.D., Editor ..... Jacksonville

Members

ANNA MARIA: Edgar W. Huth. APALACHICOLA: Photis J. Nichols. ARCADIA: F. Erwin Daves, Charles H. Kirkpatrick, Frank J. Liddy, Gordon H. McSwain. ARLINGTON: Robert H. Lester. AVON PARK: Hubert W. Coleman, Donald C. Hartwell, Samuel A. King. BARTOW: Milo H. Holden, William F. Peacock. BELLE GLADE: Wilbert O. Norville, (Col.) BOYNTON BEACH: Charles D. Akes. BRADENTON. Alfons R. Bacon, Joseph B. Ganey, Irving E. Hall Jr., Richard V. Meaney, Millard P. Quillian, Sidney Smith, William D. Sugg, Willett E. Wentzel, Frederic H. Wood. BRANFORD: Edward G. Haskell Jr. BROOKSVILLE: S. Carnes Harvard.

CALLAHAN: David D. Bennett Jr. CLEARWATER: Helen L. T. Dexter, Percy H. Guinand, Everett M. Harrison, Francis C. Hoare, John P. Lee, James B. Leonard, Raymond M. Lockwood, Sherman H. Pace, George T. Raper, Samuel T. Register, George H. Schoetker, James M. Stem, Robert T. Walker, Thomas H. Wallace. COCOA: Laurent L. LaRoche, Lee Rogers Jr. CORAL GABLES: John C. Ajac, A. Daniel Amerise, Charles R. Burbacher, Philip J. Chastain, Reuben B. Chrisman Jr., Jack Q. Cleveland, Franklin J. Evans, Maurice C. Guest, Morton M. Halpern, Edward E. Hodsdon, Paul K. Jenkins, Jim S. Jewett, Robert P. Keiser, F. E. Kitchens, James F. Lyons, Wm. W. McKibben, Norman W. McLeod Jr., Wayne B. Martin, Burton T. Meadows, Jerome A. Megna, William T. Mixson Jr., Wesley S. Nock, Robert C. Piper, Frederick P. Poppe, Warren W. Quillian, Joseph H. Rudnick, John M. Rumball, T. D. Sandberg, William P. Smith, Rollin D. Thompson, Karl W. Vetter, William L. Wagener Jr., Arthur H. Weiland, Hillard W. Willis, Bernard Yesner, Warren Zundell.

DADE CITY: W. Wardlaw Jones. DANIA: Fred E. Brammer. DAYTONA BEACH: John J. Cheleden, James W. Clower Jr., Cleland D. Cochrane, Hugh Crawford, Robert DeArmas, Peter A. Drohomer, David W. Goddard, George M. Green, Joel V. McCall Jr., Edward P. Madden, Achille A. Monaco, Howard W. Reed. DELAND: Loren A. Dunton, Theodore F. Hahn Jr., William R. Hutchinson. DELRAY BEACH: Martin E. Buerk, Frederic S. Huntington, James R. Nieder, Thomas Whitehead. DUNEDIN: James C. Fleming, John A. Mease Jr., James F. Spindler, Walter H. Winchester. EAU GALLIE: Jack T. Bechtel. FERNANDINA: Benjamin F. Dickens.

FORT LAUDERDALE: Louis L. Amato, Norris M. Beasley, Curtis D. Benton Jr., James F. Berry, Miles J. Bielek, Oliver C. Brown, Mark Butler, Milton N. Camp, Russell B. Carson, Alfred E. Cronkite, James W. Dickey Jr., Burns A. Dobbins Jr., George R. Dornberger, Frederick J. Driscoll, Robert L. Elliston, Robert S. Faircloth, J. Allan Fields, Frederick W. Fisher, Roland F. Fisher, Donald H. Gahagen, Walter J. Glenn Jr., Francis Haberman, George Hamerick, Roger K. Haugen, Anne L. Hendricks, Thomas F. Huey Jr., Garland M. Johnson, Clifton B. Leech, M. Austin Lovejoy, Thomas L. McKee, Richard A. Mills, Robert U. Moersch, Richard D. Owen, Albert A. Parrish, Claus A. Peterson, George T. F. Rahilly, Harry C. Robelen Jr., Lees M. Schadel Jr., Charles F. Seymour, Daniel C. Smith, Vincent V. Smith, Curtis H. Sory, Robert G. Talley, Alva R. Taylor, Alvin J. Tight, Charles L. Wadsworth, James M. Weaver, William D. Wells, George M. Wilcoxon, John I. Williams, Scottie J. Wilson.

FORT MYERS: Fred D. Bartleson, Gustav F. Bieber, Ernest Bostelman, James L. Bradley, Merwin E. Buchwald, James C. Carver, A. Louis Girardin Jr., Angus D. Grace, William H. Grace, George D. Hopkins II, H. Quillian Jones, Newton W. Larkum, Joseph L. Selden Jr., John S. Stewart, William M. Taylor. FORT PIERCE: Henry E. Branca, Russell L. Counts, Martin G. Gould,

Richard F. Sinnott, Laurance D. Van Tilborg, Lester L. Whiddon. FORT WALTON BEACH: Frederic E. Caldwell. GAINESVILE: Henry J. Babers Jr., F. Emory Bell, Henry S. Blank, Edward G. Byrne, Charles H. Carter, Raymond J. Fitzpatrick, George T. Harrell Jr., James M. McClamroch, John E. Maines Jr., Charles Pinkoson.

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JACKSONVILLE: Sam C. Atkinson, Sullivan G. Bedell, C. Ashley Bird, John B. Black, James L. Borland, Frederick H. Bowen, Charles W. Boyd, James M. Bryant, Charles H. Burke, Joseph Canipelli, Cornelia M. Carithers, Hugh A. Carithers, Turner Z. Cason, William H. Chapman, Cecil C. Collins Jr., Charles D. Cooksey, Wayland T. Coppedge Jr., J. K. David Jr., Lucien Y. Dyrenforth, Joseph A. J. Farrington, Emmet F. Ferguson Jr., John J. Fisher, Frank L. Fort, John M. Gorman, A. Judson Graves, Vernon T. Grizzard Jr., Leonard H. Grunthal Jr., Karl B. Hanson, Arthur L. Hardie Jr., Albert V. Hardy, O. E. Harrell, Tyndall P. Harris, William G. Harris, John W. Hayes, Phillip W. Horn, Floyd K. Hurt, William Ingram Jr., Gordon H. Ira, Ivan Isaccs, F. Gordon King, Raymond H. King, Elmer E. Leitner, Camillus S. L'Engle Jr., Thomas H. Lipscomb, Samuel S. Lombardo, John F. Lovejoy, Joseph J. Lowenthal, James G. Lyerly, E. Frank McCall, Bernard J. McCloskey, Charles F. McCrory, Robert B. McIver, Carl C. Mendoza, John H. Mitchell, Bernard L. N. Morgan, Thomas E. Morgan, Kenneth A. Morris, Nelson A. Murray, Melvin Newman, Aaron Z. Oberdorfer, Lorenzo L. Parks, George I. Raybin, Richard V. Reiswig, Wade S. Rizk, Clarence M. Sharp, Richard G. Skinner Jr., Lauren M. Sompayrac, Wilson T. Sowder, Sidney Stillman, George M. Stubbs, Max Suter, Richard P. Thompson, Daniel R. Usdin, William A. Van Nortwick, Frederick J. Waas, Leo M. Wachtel Jr., Edward C. Watt, Carl H. Wells, Louis A. Wilensky, Albert H. Wilkinson, Ashbel C. Williams, J. Frank Wilson.

JACKSONVILLE BEACH: Charles F. McKay. KEY WEST: Ralph Herz. LAKE ALFRED: Kenneth W. Jackson. LAKE CITY: Laurie J. Arnold Jr., Louis G. Landrum. LAKELAND: Robert M. Akey, Clarence L. Anderson, Jere W. Annis, James R. Boulware Jr., John E. Daughtrey, Fred I. Dorman Jr., Ralph B. Hanahan, Marion W. Hester, William A. Hodges Jr., William S. Johnson, David S. Kenet, William M. Kummer, Coy L. Lay, George H. Mix, James T. Shelden, David Sloane, John W. Vaughn, Edgar Watson, S. L. Watson, John W. Williams, LAKE WALES: Williard E. Manry Jr. LAKE WORTH: Leonard W. Appleby, Richard F. Kidder, Carl M. Pults, Arthur T. Rask, H. John Richmond, Alva L. Rowe, A. Scott Turk.

LARGO: Harry M. Katz. LEESBURG: H. Durham Young Jr. MARATHON: Elmer J. Eisenbarth. MARIANNA: James T. Cook Jr. MELBOURNE: Oswald A. Holzer, Theodore J. Kaminski, Isabel Roberts, James A. Sewell, Arthur C. Tedford, Ludo von Meysenbug.

MIAMI: Bernard Abel, Lawrence Adler, Julius Alexander, Lassar Alexander, James L. Anderson, William A. D. Anderson, Samuel Aronovitz, William G. Aten Jr., Harold P. Auslander, George C. Austin, J. Ernest Ayre, Hubert A. Barge, William J. Barge, Ernest R. Barnett, Jack W. Barrett, Harry E. Beller, Morris H. Blau, David Brezin, John A. Broward, Andrew G. Brown, Earlsworth C. Brunner, John E. Burch, Gerard F. Carter, Chester Cassel, Turner E. Cato, Silas E. Chambers, Isaac B. Cippes, Herman Cohen, Benjamin Coleman, George D. Conger, Francis N. Cooke, Milton M. Coplan, Vincent P. Corso, Edward W. Cullipher, DeWitt C. Daughtry, Carl H. Davis, H. Clinton Davis, Harold E. Davis, John E. Dees, Robert F. Dickey, John W. Dix, Percy L. Dodge, L. Washington Dowlen, Otto S. Dowlen, Carl E. Dunaway, James O. Elam, Lee W. Elgin, Wm. H. Ellis, Bruce M. Esplin, Charles D. Ettinger, Frederick E. Farrer, Willard L. Fitzgerald, M. Eugene Flipse, M. Jay Flipse, Roger J. Forastiere, Sidney Fox, Tom R. Gammage, Edmond Gamse, Hollis F. Garrard, Michael M. Gilbert, George Gittelson, Herman Glassman, Francis W. Glenn, James J. Goodman, J. Raymond Graves, Maurice M. Greenfield, Thos. S. Griggs, Howard H. Groskloss, Daniel O. Hammond, John V. Handwerker Jr., Henry C. Hardin Jr., Robert M. Harris, Benedict R. Harrow, W. Tracy Haverfield, Maurice E. Heck, Ella M. Hediger, Francisco A. Hernandez, Andrew H. Hinton, James W. Holmes, H. Carlton Howard, Karen Howard, Paul E. Howard, R. Spencer Howell, Jack Humphreys, James J. Hutson, Emil M. Isberg, William H. Izlar, Ralph W. Jack, Truxton L. Jackson, Joseph T. Jana Jr., Paul S. Jarrett, Albert C. Jaslow, Walter C. Jones, Samuel Kaplan, Harold S. Kaufman, Jacob Kaufman, Christian Keedy, Jack Keefe III, Theodore C. Keller, Ralph E. Kirsch, David Kirsh, Erna K. Klass, Alexander Kushner, William T. Lanier, Robert B. Lawson, Frederick LeDrew, Hilbert A. P. Leininger, Louis Lemberg, Lee W. Lerner, Alfred G. Levin, George D. Lilly, Warren Lindau, Simon M. Lipton, George Lister, A. Buist Litterer, Joseph Lomax, Manuel C. Lores, Robert O. Lyell, E. Norton McKenzie, Jack A. McKenzie, Jesse C. McMillan, Robert A. McNaughton, Martin P. Mahrer, Plumer J. Manson, Donald F. Marion, Isidore Marx, Lawrence R. Medoff, Matthias P. Meehan, Hyman Merlin, John B. Miale, Saul Miller, Leon H. Mims Jr., Harry M. Moore, C. Russell Morgan Jr., S. Robert Nash, Florence Nathanson, Samuel Neustein, Russell K. Nuzum, Arturo C. Ortiz, Frazier J. Payton, Colquitt Pearson, Homer L. Pearson Jr., Nelson T. Pearson, M. Sewell Pender, Max Pepper, Roland F. Phillips, Ralph L. Pipes, Edwin P. Preston, James H. Putman, Harold Rand, Homer A. Reese, Maurice Rich, John R. Richardson, Julian Robinson, Reuben Rochkind, Hunter B. Rogers, Charles Rosenfeld, Manning J. Rosnick, David R. Rothrock, Robert L. Roy, Ruth W. Rumsey, Lyle W. Russell, Walter W. Sackett Jr., Wiley M. Sams, Ralph S. Sappenfield, Chaffee A. Scarborough, Oden A. Schaeffer, George F. Schmitt Jr., Manuel A. Schofman, John M. Schultz, Donald W. Smith, Clifford C. Snyder, John W. Snyder, John A. Speropoulos, A. Lester Stepner, Franz H. Stewart, Joseph S. Stewart, Chauncey M. Stone Jr., William M. Straight, Richard E. Strain, Collins W. Swords Jr., Kelly C. Thomas, Herbert W. Virgin Jr., Theodore J. C. von Storch, Robert M. Watson, Robert C. Welsh, Kenneth S. Whitmer, William Wickman, Edward H. Williams, George Williams Jr., Oliver P. Winslow Jr., Elliott T. Witkind, Arthur W. Wood Jr., Frank Woods, Leo S. Wool, John E. Wright, Meyer Yanowitz, Corren P. Youmans.

MIAMI BEACH: Mortimer D. Abrashkin, Bernhard Baer, Theodore M. Berman, Charles I. Binder, Otto S. Blum, Herman Boughton, Judd R. Breakstone, Lewis Capland, Marcus B. Cirlin, Elliott C. Cohen, Max Dobrin, Maurice I. Edelman, Howard A. Engle, David W. Exley, Jack J. Falk, I. Leo Fishbein, Richard M. Fleming, Stanley Frehling, Elias Freidus, Jacob A. Glassman, Milton S. Goldman, Bernard Goodman, Max Gratz, Robert J. Grayson, Irvin M. Greene, Abraham R. Hollender, Walter T. Hotchkiss, Lewis L. Julien, Saul H. Kaplan, Joseph D. Katzman, Harry Kaufman, Bernard S. Kleinman, Samuel B. Kleinman, Maurice D. Krauss, Wilfred Lansman, Andrew J. Leon, George N. Leonard, Leo M. Levin, Sanford Levine, Alexander Libow, Charles Lippow, Joseph H. Lucinian, Louis G. Lytton, Leon H. Manheimer, Marvin L. Meitus, David A. Nathan, Julius R. Pearson, Jean J. Perdue, Paul Plotkin, Joseph B. Pomerance, Julian A. Rickles, Maurice J. Rose, Edward Roth, Leonard G. Rowntree, Seymour W. Rubin, Stan-

ley E. Schwartz, Sol Selevan, Benjamin L. Steinberg, John H. Tanous, Efton J. Thomas, Rene A. Torrado, M. P. Travers, Harold D. Van Schaick, Harrison A. Walker, Arthur L. Walters, Leonard L. Weil, D. Ward White, Daniel H. Zimmerman, Nelson Zivitz.

MIAMI SHORES: Frank T. Sheehan. MIAMI SPRINGS: Bernard Halperin, Carrol E. Parrish, Clyde T. Thompson. MOUNT DORA: Sanford C. Colley, Robert H. Montgomery, Alexander E. Morse Jr. MULBERRY: John A. Ray. NAPLES: Earl S. Davis, Ethel H. Trygstad, Reidar Trygstad. NEWBERRY: George W. Karelas. NEW SMYRNA BEACH: James J. Cunningham, James F. Robertson, Russell L. Welsh. NOKOMIS: James E. Blades. NORTH MIAMI: Valentine Bloch, Ludwig M. Ungaro. OCALA: Hugh H. Barfield, Harry M. Edwards, Henry L. Harrell, Eugene G. Peek Jr., Harry F. Watt. OCEANWAY: William E. Lamb. ORLANDO: Benjamin L. Abberger Jr., Clarence Bernstein, Rex M. Bleakney, Frank C. Bone, Benjamin L. Brock, Thomas C. Butt, Benjamin M. Cole, Chas. J. Collins, Norman F. Coulter, Francis M. Coy, Robert W. Curry, Horace A. Day, W. Ansell Derrick, Charles F. Dillon Jr., Paul H. Ducharme, Elwyn Evans, James B. Glanton, Benjamin Glaser, Frank D. Gray, George W. Griffin, G. Tayloe Gwathmey, Richard C. Hartsfield, David Y. Hicks Jr., Aubrey T. Hornsby, J. Cornall Howarth, Joseph L. Hundley, Eugene L. Jewett, Eldridge W. Johnson, Solomon D. Klotz, Ian J. Macdonald, Newton C. McCollough, Duncan T. McEwan, John D. McKey, Carl S. McLemore, James A. McLeod, Charlotte C. Maguire, Meredith Mallory, John G. Marsh, Fred Mathers, Joseph G. Matthews, Alexander P. Maybarduk, Royston Miller, William S. Mitchell, Pleasant L. Moon, Louis C. Murray, Leo C. Nickell, Joseph E. O'Malley, Louis M. Orr, Roger E. Phillips, Louis E. Pohlman, Frank J. Pyle, Don C. Robertson, Jack F. Schaber, George P. Schanck Jr., (Col.), Adelbert F. Schirmer, Joseph G. Seltzer, Rodman Shippen, Charles R. Sias, Philip F. Simensky, Joseph L. Stecher, Wade N. Stephens, Ernest J. Stevens, Alfred S. Stevenson, W. Dean Steward, Byrne E. Taylor, Robert L. Tolle, Jack P. Ward, Merrill Wattles, Peter B. Wright, Robert W. Young, Robert E. Zellner. PAHOKEE: Ernest C. Johnson Jr. PALATKA: Lawrence G. Hebel. PALM BEACH: David A. Newman, Bailey B. Sory Jr. PANAMA CITY: James F. Cason, Jack Corbitt, William F. Humphreys Jr., Joseph H. Morris, William C. Roberts, C. W. Shackelford. PENSACOLA: Bernard M. Barrett, Pascal G. Batson Jr., Herbert L. Bryans, Arthur J. Butt, William P. Hixon, Frank B. Hodnette, Alpheus T. Kennedy, Albert Lehmann, Mozart A. Lischkoff, William W. Miller Jr., George W. Morse, Wendell J. Newcomb, Walter C. Payne Sr., Samuel B. D. Rhea, Joseph L. Rubel, Gretchen V. Squires, Raymond B. Squires, Alvin L. Stebbins, William M. C. Wilhoit, Dale E. York.

PERRY: Charles R. Wiley. PLANT CITY: William G. Meriwether, Madison R. Pope. POMPANO BEACH: Frank L. Mikes. PONTE VEDRA: Alda G. Holliday. PORT ST. JOE: Joseph P. Hendrix. QUINCY: Taylor W. Griffin, George H. Massey, Hilliard R. Reddick. RIVIERA BEACH: Frank M. Hewson Jr. ROCKLEDGE: Myron L. Habegger, John C. Miethke. ST. AUGUSTINE: Reddin Britt, S. Raymond Cafaro, William J. Gibson, Vernon A. Lockwood, Donald T. Rankin, Herbert E. White. ST. CLOUD: Robert G. Wood.

ST. PETERSBURG: Arnold S. Anderson, Clyde O. Anderson, George H. Anderson, Grover W. Austin, Orion T. Ayer, (Col.), Walter H. Bailey, Kenneth A. Baker, William K. Barton, Bernard T. Bell, Curtis W. Bowman, John P. Boyle, Elmer B. Campbell Sr., Elmer B. Campbell Jr., Donald D. Carter, John H. Cordes Jr., Harry R. Cushman, David K. Davis, Charles K. Donegan, John W. Dowswell, Woodrow B. Estes, Ira C. Evans, Chas. L. Farrington, John P. Ferrell, Cornelius S. Franckle, Leonard Freed, William D. Futch, N. Worth Gable, Abraham J. Gorday, Sidney Grau, George F. Hieber, John P. Hobach, Douglas W. Hood, L. Wayne Johnson, Frederick C. Knight, Norval M. Marr Jr., Daniel F. H. Murphey, Orville N. Nelson, Walter Rautenstrauch Jr., Harry F. Rolfes, John P. Rowell, Walter L. Schafer, Richard H. Sinden, Benjamin H. Sullivan, Paul F. Wallace, Kenneth Weiler, Ralph M. Wimbish, (Col.), Rowland E. Wood.

SANFORD: Orville L. Barks, Terry Bird, J. Clifford Boyce, Leonard Munson, Charles L. Park Sr. SARASOTA: George A. Bishopric, John M. Butcher, George M. Coggan, Thomas G. Dickinson, Michael A. DiCosola, Rudolph C. Garber Jr., Laurence W. Gregory, Eugene D. Liddy Jr., Henry G. Morton, Hugh G. Reaves, Karl R. Rolls, Thomas F. Scott, Melvin M. Simmons, Benjamin F. Stein, Henry J. Vomacka, Samuel R. Warson, Millard B. White, Reaves A. Wilson. SEBRING: Leldon W. Martin. SOUTH MIAMI: Henry H. Bryant, Donald E. Fortner, John F. McKenna, James H. Mendel Jr., Franklyn E. Verdon.

STUART: Walter F. Davey. TALLAHASSEE: Edson J. Andrews, Thomas J. Bixler, Paul J. Coughlin, Laurie L. Dozier, Francis T. Holland, William J. Hutchison, Charles F. James Jr., Clarence W. Ketchum, Robert H. Mickler, Raney A. Oven, George S. Palmer, Luther L. Pararo Jr., Naomi T. Stinger, William R. Stinger, Robert N. Webster. TAMPA: Samuel H. Adams, Leonard S. Annis, Efrain C. Azmitia, Richard A. Bagby, Collin F. Baker Jr., Arthur R. Beyer, Ernest R. Bourkard, C. MacKenzie Brown, J. Robert Campbell, Leffie M. Carlton Jr., Harold Carron, Edward F. Carter Sr., Charles Catanzaro, C. Frank Chunn, Herschel G. Cole, Richard G. Connar, Lewis T. Corum, James T. Cowart, Oliver F. Deen Jr., Thomas W. Dorr, R. Renfro Duke, Thomas M. Edwards, Gaetano C. Ferrante, Joseph C. Flynn, Eugene S. Gilmer, Leo C. Gonzalez, Charles McC. Gray, H. Phillip Hampton, John S. Helms Jr., Samuel G. Hibbs, Richard S. Hodes, James B. Hodge Jr., J. M. Ingram, Frank H. Lindeman Jr., Frank T. Linz, Blackburn W. Lowry, Myron L. McEachern, Thomas E. McKell, Alfonso F. Massaro, Eugene B. Maxwell, Richard J. Miller Jr., Joseph A. Minardi, David R. Murphey Jr., Wade C. Myers Jr., Harold G. Nix, Julien C. Pate Jr., James N. Patterson, Joseph A. Pendino, Neal J. Phillips, Curtis G. Rorebeck, William M. Rowlett, Joseph J. Ruskin, Zack Russ Jr., Hawley H. Seiler, Edward F. Shaver, Marshall E. Smith, Wray D. Storey, Joseph W. Taylor, Mason Trupp, Morris Waisman, Augustine S. Weekley, Dwight J. Wharton, Frances C. Wilson, Wesley W. Wilson, Robert W. Withers, Lester L. Zipser.

TARPON SPRINGS: James E. Thompson. TAVARES: J. Basil Hall, James R. Hanson. VENICE: Samuel E. Kaplan, Douglas R. Murphy. VERO BEACH: William L. Fitts 3rd., John P. Gifford, Erasmus B. Hardee, Walter W. McCorkle. WEST MIAMI: Robert B. Ward. WEST PALM BEACH: Willard F. Ande, James R. Anderson, Carl E. Andrews, Robert V. Artola, John M. Baber, R. Henry Baldwin, Harry E. Bierley, William E. Bippus, Edwin W. Brown, Victor Clarholm, Joseph J. Daversa, C. Jennings Derrick, Hugh Dortch Jr., William H. Everts, W. Wellington George, Richard S. Gill, Charles McD. Harris Jr., V. Marklin Johnson, Edgar A. P. Kellerman, R. Gaylord Lewis, Philip O. Lichtblau, W. Ambrose McGee, David W. Martin, Glenn H. Morton, Lloyd J. Netto, Walter R. Newbern, Bernard F. O'Hara, Ralph M. Overstreet Jr., Cecil M. Peek, Raymond R. Preefer, Raymond S. Roy, Lauchlin M. Rozier, William Y. Sayad, Murray D. Sigman, Joseph R. Skyer, Roslyn Skyer, James R. Sory, Edgar W. Stephens Jr., Laurie R. Teasdale.

WINTER GARDEN: John J. Scanlon. WINTER HAVEN: Richard D. Field, Henry F. Keiber, Arthur J. Moseley Jr., Chester L. Nayfield. WINTER PARK: Walter B. Johnston, Albert C. Kirk Sr., William L. Musser, Frank W. Nickel, Charles D. Price, Leroy S. Safian, Henry J. Wiser. WILLISTON: James Weres.

Visiting Doctors

ARCADIA: Joseph W. Lawrence. BOYNTON BEACH: Ben H. Barbour Jr., Jack H. Raulston. CHATTAHOOCHEE: Lindsey D. Campbell. CLEAR-

WATER: Morris W. Dexter. CORAL GABLES: Henry Barancik, William E. Berkey, Paul W. Boyles, Milton P. Caster, Victor Dabby, Kermit H. Gates, Herbert S. Kaiser, James W. Lancaster, Irwin S. Morse, Jack Reiss, Gaetano T. Samartino, Burnett Schaff, Sylvan A. Schotz, Robert C. Schwartz, Emanuel M. Stadlan, Jay N. Wemple, Walter M. White Jr. FORT LAUDERDALE: Rosarie Bender. GAINESVILLE: Clara P. Haupt. HIALEAH: Theodore Hirsch. HOMESTEAD: Benjamin L. Archer, Robert A. Douglas, Kenneth H. McCrocklin. JACKSONVILLE: James O. Bond, Thomas B. Christian, John Q. Durfey, John L. Mitchell, W. Laney Whitehurst.

KEY WEST: F. J. Hill. MIAMI: Harold Albert, George S. Baldry, David L. Crane, George P. Daurelle, Claude G. Eccles, Albert J. Ehlert, Leonard A. Erdman, George M. Erickson, John J. Farrell, Donald B. Frankel, Marvin S. Freedland, Joseph R. Galluccio, Maxwell N. Greenhouse, James M. Harsha, H. Donald Hill, A. Gorman Hills, Simon I. Kemp, Max M. Kulvin, John M. Langstaff, Taylor Lewis, Abraham Lustgarten, Paul D. Mabie, Ronald J. Mann, David R. Millard Jr., Douglas C. Morris, Robert R. Nardone, James Nesbitt III, Lloyd R. Newhouser, Humberto M. Nogueiras, Alfred E. Ogden, John R. Pearson, Norman V. Rothwell, Samuel C. Rumore, Richard E. Schindler, Louis W. Schneider, M. David Sims, Oliver A. Smith, Thomas J. Zaydon.

MIAMI BEACH: Irving H. Blumenfeld, Maryland B. Byrne, Lee W. Elgin Jr., J. M. Houston, Donald A. Kullman, Pedro L. Lardizabal, Diego Menigatti, David K. Pinks, Jacob Rockman, Melvin Simonson. MULBERRY: Leonard L. Bratcher. NORTH MIAMI: John A. Heffernan.

ORANGE SPRINGS: Ralph W. McComas. PENSACOLA: Nathaniel B. Slonim. SAFETY HARBOR: David P. Wollowick. ST. PETERSBURG: H. W. Carter, Richard M. Free, Alfred D. Koenig. SOUTH MIAMI: Marie L. A. Schuh. TAMPA: Jonas Carron, Maurice Haddad, S. Victor Kassels. WEST HOLLYWOOD: Donald L. Peterson. WEST PALM BEACH: Pierce Weinstein, Jack E. Wright.

ALABAMA-BIRMINGHAM: Arthur W. Woods. FAIRHOPE: Wm. F. Gessler Jr. MOBILE: H. S. Cowley. MONTGOMERY: Irving D. London. CALIFORNIA-SAN FRANCISCO: John W. Cline. COLORADO-COLORADO SPRINGS: T. R. Knowles. DISTRICT OF COLUMBIA — WASHINGTON: Foard G. McGinnes. GEORGIA-ADEL: Fred N. Clements. ATLANTA: Needham B. Bateman, Leland K. Glenn, R. F. Hand. SAVANNAH: Vincent J. Cirincione. ILLINOIS-CARMI: Eugene W. Dach. CHICAGO: Thaddeus F. Bak, John G. Bellows, James J. Callahan, Raul M. Casas, Bernard V. Chern, Joseph E. Faingold, Eugene Grosz, Louis C. Johnston, Harry R. Keiser, H. J. Lawn, Paul R. Prager, Thaddeus A. Wozniak. MOUNT VERNON: M. Zelman. INDIANA-INDIANAPOLIS: Francis P. Jones, John S. Stanley. WINCHESTER: Paul W. Sparks. KENTUCKY-LOUISVILLE: Harry Goldberg. LOUISIANA-MONROE: Sol I. Courtman. NEW ORLEANS: Leon Hart, Laurence F. McCune, MASSACHUSETTS-BARRE: John R. Fowler. BOSTON: H. Homer LeClair, Shields Warren. MICHIGAN-BAY CITY: F. Pitkin Hustead. DETROIT: S. Knappenberger, Ruben Meyer, George B. Paxton Jr., Nathan H. Schlafer, Claibourne P. Shonnard, Roger F. Smith, John Van Boven.

MISSOURI-INDEPENDENCE: W. H. Hickerson. MONTANA-BILLINGS: Martin A. Ruona. NORTH CAROLINA-ASHEVILLE: Claude A. Frazier, Donald R. Printz. DURHAM: Edwin P. Alyea. WINSTON-SALEM: James P. Rousseau.

NEW YORK-BROOKLYN: Edwin M. Gold, Oscar Levine, Phillip I. Leviton, Harry H. Weiss. NEW YORK CITY: Robert G. Hyams, William H. Mencher, Anna Weintraub, Hyman Wohl. ROCHESTER: Simon L. Wronker. ROCKVILLE CENTRE: Charles J. Preefer. OHIO-CLEVELAND: Frank J. O'Dea. DAYTON: Harry A. Nieman. MOUNT VERNON: Julius Shamansky. OKLAHOMA-MIDWEST CITY: Arnold G. Nelson. TULSA: Summer Y. Andelman. NEW JERSEY-HACKENSACK: Milton G. Abarbanel. SUMMIT: Jock L. Graeme, F. J. Vinci. PENNSYLVANIA-HAVERFORD: James I. Hykes. PHILADELPHIA: Harvey Blank, J. Stanley Cohen, Sherman A. Eger, Thomas D. Goshen, Leslie Nicholas, Lauren H. Smith. PITTSBURGH: Irving L. Shonberg. TENNESSEE-CAMDEN: Ranel B. Spence. MEMPHIS: Moore Moore Jr. NASHVILLE: George K. Carpenter. TEXAS-AUSTIN: Gretchen S. Runge, Thomas M. Runge. BASTROP: C. G. Goddard. GALVESTON: Thomas J. Baker. KILGORE: Robert B. Eckels. VIRGINIA-ROANOKE: Yudell K. Slocum. WISCONSIN-MILWAUKEE: Lionel T. Servis, Ralph E. Teitgen. WARD: Joseph Kanter. BAHAMAS-NASSAU: Norman Kerr. CANADA-ALBERTA-EDMONTON: Eliot Wershof. REPUBLIC OF PANAMA-COLON: Harry Eno.

ANNUAL JOINT REPORT

Secretary-Treasurer, Samuel M. Day, M.D.
Managing Director, Ernest R. Gibson

The Association continues to grow and progress steadily, keeping pace with the rapid development of the state with its unprecedented increase in population.

The construction of the permanent headquarters building at 735 Riverside Avenue, Jacksonville, appears to be on schedule. Occupancy is anticipated in late summer. We believe that it will add greatly to the efficiency of the executive office, improve service to members and provide tangible evidence of the medical profession's contribution to public welfare.

Following is a summarization of the activities of the several departments which make up the executive office:

PUBLICATIONS

Major activities of the Department of Publications are processing The Journal, a substantial assignment in itself, preparation and distribution of the newsletter "Briefs" and multilithing. Other responsibilities include the production of the Florida Medical Directory, House of Delegates Handbook, Annual Meeting Program, District Meeting Program, annual revision of the Constitution and By-Laws, and mailing the quarterly Journal of the Florida Academy of General Practice.

The department is efficiently supervised by Mr. Tom Jarvis, who doubles in brass as Assistant Managing Editor of The Journal. He is assisted by the Journal Technician, Mrs. Louise Rader. The Journal is one of the few publications of its kind blessed with the services of an experienced, able editorial consultant, Mrs. Edith B. Hill.

The Journal

Production costs of The Journal this fiscal year have been greater due to increases in the price of printing and paper. An increase in display advertising rates will be placed in effect as current contracts expire. Present revenue from advertising pays for printing and paper. Some direct advertising accounts have been obtained and efforts will continue to secure more.

This year 38,275 copies of The Journal were printed, an increase of 3,831 over the previous year. The increase was primarily due to increase in membership of the Association.

The stock of back issues of The Journal is being cut to a minimum because of printing costs. This means that it may not always be possible to fill requests for back issues.

A more detailed report on The Journal may be found in the Report of the Editor, Dr. Shaler Richardson, scheduled for publication in the July issue.

"Briefs"

A total of 14 issues of "Briefs" has been printed and mailed to members this year. Preparation of copy is not always by this Department. It may originate with the Managing Director or Supervisor of the Bureau of Public Relations, depending upon the subject matter. "Briefs" is not issued on an established schedule. It is sent only when there is information believed to be valuable to the members.

Multilithing

More than one half the stationery used by the Association's Executive Office is printed by the Department. Other jobs include forms, reports, booklets, letters and the Auxiliary Yearbook. This gives a substantial saving in printing costs throughout the year.

Directory

Utilizing copy prepared by other departments, Publications is responsible for the art work, design, layout, production and distribution of the annual Association Directory, a copy of which is sent each member without charge. Copies are sold to others at $2.00 each which produced revenue of $2,080. Cost of printing the Directory has increased due to the price of printing and paper. A few new advertising accounts were obtained through direct mail solicitation.

House of Delegates Handbook

From copy obtained from the Administration Department, the design, layout and production of the Handbook is accomplished.

Programs

Utilizing the type set for The Journal, the Department produces the programs for the Annual Meeting and the Medical District Meetings. It is responsible for the art work, design and layout.

Constitution and By-Laws

Production of the annual revision of the Constitution and By-Laws takes place as soon after the annual meeting as practicable.

Journal of the Florida Academy of General Practice

Quarterly the Department addresses and mails the Journal of the Florida Academy of General Practice using the mailing facilities of the Association. This is a service performed for the Academy at its request at an agreed rate of two cents per copy addressed. This reimburses the Association for the approximate cost of the service.

PUBLIC RELATIONS

The policies of the Bureau of Public Relations are determined by the Board of Governors and implemented through its liaison member for public relations and the Committee on Legislation and Public Policy. The Bureau is directed by W. Harold Parham, Supervisor, who also serves as the Association's Assistant Managing Director. Eugene L. Nixon was selected last year as Assistant Supervisor and Miss June Palmer recently joined the staff and serves as secretary for the Bureau.

The Bureau has been engaged primarily in promoting, planning and coordinating the Association's public relations and legislative programs. The public relations program is outlined in the Association's publication entitled "A Positive Program of Public Relations."

Field work has taken a great deal of the time of the Bureau's staff, as in previous years. The officers and committee chairmen of county medical societies have been contacted, many on several occasions, to promote and coordinate the programs over the state. Various State of Florida officials, legislators and other influential individuals, newspapers, radio and television stations, allied and civic organizations, have been contacted in an effort to bring about a closer relationship and better understanding of the Association's objectives and activities.

The Association has continued to cooperate in the rural health program with the Agricultural Extension Service of the two state universities, the Florida Farm Bureau Federation and the State Board of Health. Various educational services such as speakers and literature have been provided to interested groups upon request. The Florida Medical Association's award in health improvement, which was initiated in 1954 and is presented to the outstanding rural youth in health achievement in the state, was continued this year. For the purpose of evaluating the rural health program a statewide conference was held in September, sponsored by the Association, with representatives of the participating organizations in attendance.

Publicity for the Association's annual convention, district meetings and other activities of interest has been processed by the Bureau. Efforts were made during the year to increase and maintain good relations with all public information media through public contact, correspondence and further implementation of the code of cooperation between physicians, hospitals, press, radio and TV. Medical information has been brought continuously to the public by the weekly column "Health Topics" and additional newspapers have been added to the mailing list.

Television films and transcribed radio programs on health subjects were distributed to stations through the Bureau in cooperation with the county medical societies. Continued attempts are being made to present these programs in areas which had little or no previous radio or television service. The use of the medium of television by county societies is increasing greatly.

Medical fair exhibits were obtained and assistance was provided for displays at the North Florida Fair, Tallahassee; Florida State Fair, Tampa; Central Florida Fair, Orlando; and the Southwest Florida Fair, Fort Myers; and at the University of Miami. All showings were co-sponsored by the respective county medical societies and the Association, with the exception of the Florida State Fair, where the state association was the exhibitor. The success each of these exhibits enjoyed served to emphasize the importance of this means of reaching the public with valuable medical information.

County medical societies have been assisted by the Bureau with special projects such as medical forums, live radio and TV programs, exhibits, improving emergency call services, press, radio and television relations and other general public relations activities.

Two new projects now underway include the establishment of closer cooperation between physicians and attorneys in Florida and a study of organized labor as it relates to medical practice.

This past year great emphasis has been placed upon assisting the Committee on Legislation and Public Policy in coordinating and carrying out projects relating to national legislation and our state legislative program. The Supervisor maintained an office in Tallahassee during the entire 1955 session of the Florida legislature to provide information to legislators pertaining to the Association's legislative program, to steer the Association's bills through and maintain a constant check on all legislation. Four of the six bills sponsored by the Assoication during the session passed and became law. The Association was influential in the passage of pertinent legislation sponsored by other groups and was also responsible for the defeat of a great deal of undesirable health legislation.

The Bureau has assisted other committees of the Association upon request and also the advisory Committee on Hospital Service for the Indigent of the State Board of Health in the implementation of this program.

The responsibility for local public relations projects and implementation of the legislative program rests with the respective county medical societies. The facilities of the Bureau are available to the county medical societies for planning and assistance with local programs. The societies are urged to use these facilities.

ADMINISTRATION

Through the General Office are channeled the numerous directives of the House of Delegates, the Board of Governors and the Managing Director. This department may well be termed the hub of the Association's headquarters from which the other departments obtain sustenance for the fulfilment of their many activities.

In this division, under the direction of Mrs. Zoe Pack, Office Manager and senior member of the Association's staff in years of service, bookkeeping records are maintained, inventories checked and purchasing processed. Other staff members in this department, in order of seniority, are Mrs. Mae Mason, Misses Frances Pesce and Helen Vathis and Mrs. Elda Harris.

Membership Records

In this department the records of all Florida licensed doctors, with separate listings for members, are processed and kept current. Each November this department carefully checks all records and prepares copy for the annual Directory which is turned over to the Publications Department for printing. Both State and AMA dues are collected and processed by this department. This year the Association's net membership gain totaled 166. Total membership at the end of the fiscal year, March 20, was 2,909.

Annual Meeting

Preparations are started for the next annual meeting even before the current one is completed.

Assistance is rendered the Scientific Work Committee in inviting the membership and specialty groups to consider the presentation of papers and exhibits at the annual meeting. In November, the Scientific Work Committee meets to select its program after which it is necessary to advise each of the applicants of the committee's selections.

The specialty groups are contacted regarding the schedule and programs of their individual groups.

The convention hotel is advised of our needs and many hours as well as a large volume of correspondence, telephone calls and personal contacts are required to complete the details connected with a large meeting.

Each of our annual meetings is greatly enhanced by the participation of the many drug, surgical and specialty firms who spare no expense in presenting a vast array of the latest scientific developments and technics. The gross proceeds from technical exhibit space, $15,650 for the current fiscal year, add substantially to the Association's income.

During the meeting stenographic and clerical duties are performed by our staff in connection with registration, House of Delegates' sessions, reference committee meetings and scientific assemblies. The assembled material is typed, edited and turned over to the Publications Department for printing in the Proceedings Number of The Journal.

Orientation

Each new member of the Association is furnished several pamphlets to acquaint him with the purposes and activities of his state association. He is advised that the Association's headquarters office stands ready to be of assistance when called upon.

Placement

Listings are maintained on communities seeking doctors and every effort is made to assist all Florida licensed doctors seeking a location in the state to obtain one of their choice, provided approval is received from the local medical society and a need is definitely established.

General

This department correlates information, maintains filing systems, current mailing lists, and many other services which are essential to the programs of both the Publications and Public Relations Departments. The minutes of all official meetings of the Association are maintained in this department as well as a large volume of daily correspondence. Masters for Briefs, committee booklets, forms, and other items are prepared for multilithing by the Publications Department.

Assistance is rendered the chairmen of all standing committees as required. Close contact is maintained with the activities of the Woman's Auxiliary and during the past year the Association's headquarters office prepared the anual Yearbook for the Auxiliary.

Finances

The Association's building program, now drawing to a successful conclusion, accounts for $78,841.38 of the $200,637.43 current year's disbursements. This sum should be considered a transfer of assets and not an expense. Receipts for the current fiscal year totaled $145,367.72. Prices on printing and paper stock as well as some other supplies continue to rise, however, it is anticipated this will be offset to some extent by the continued increase in the Asociation's membership.

The financial statements appearing at the end of this report are published for the information of the members. The books and records of the Association are open to the members and we will gladly endeavor to answer inquiries of any nature upon request. The books have been audited by Goodrich and Varnedoe, Certified Public Accountants, and a certificate of the audit is incorporated in the statements which follow.

Respectfully submitted,
Samuel M. Day, M.D., *Secretary-Treasurer*
Ernest R. Gibson, *Managing Director*

May 3, 1956

Dr. Samuel M. Day, Secy.-Treas.
Florida Medical Association
Jacksonville, Florida

Dear Sir:

In compliance with request of Mr. Ernest R. Gibson, Managing Director, Florida Medical Association, we have examined the books of account, vouchers and other records of the association, maintained in his office, for the period March 21, 1955 to and including March 20, 1956, and submit herewith our report consisting of:

EXHIBIT "A"— Balance Sheet, March 20, 1956
EXHIBIT "B"— Statement of Receipts and Disbursements for the period March 21, 1955 through March 20, 1956
EXHIBIT "C"— Schedule of Investments, March 20, 1956
EXHIBIT "D"— Schedule of Changes in Net Worth

We determined that all recorded receipts were deposited to the credit of the association, and that the disbursements appeared to be for proper purposes. The item on the liabilities side of Exhibit "A," under caption "Reserve For Deferred Income" is the aggregate of the membership dues unpaid as at March 20, 1956 and the amount due the Journal Fund by advertisers.

The investments in U. S. Treasury and Savings Bonds were verified by actual count in the safe deposit vault. The bonds are shown in detail on Exhibit

"C," which also indicates the redemption value as of March 20, 1956 and certain bonds which have matured. These matured bonds should be redeemed as interest will not be paid after the maturity date. For your information, the interest collection on U. S. Treasury Bonds is tabulated below:

PERIOD	*AMOUNT*	
12/15/53	$200.00	
6/15/54	200.00	
12/15/54	200.00	
6/15/55	200.00	
12/15/55	200.00	$1,000.00

Land was acquired during the past year as the site for permanent quarters for the association. A contract amounting to $114,870.00 was awarded to Gallespie Construction Company for the erection of an office building—progress payments made to date total $38,-932.20, leaving a remainder of $75,937.80, which will be paid from time to time as progress reports are submitted by the contractor. An analysis of the building cost of $44,125.07, as shown on the balance sheet, is submitted as follows:

Advertising — Demolition		$ 11.05
Lot Survey		275.00
Insurance		6.93
City & County Taxes		473.76
Architect Fee		4,594.80
Payments to Contractor		38,932.20
		$44,293.74
Less		
Sale of Building	$150.00	
Refunds	18.67	168.67
Net Cost		$44,125.07

We made no attempt to verify amounts due from various county societies or by advertisers in the Journal.

Yours very truly,
(Signed) Goodrich & Varnedoe
CHG/d Certified Public Accountants

Exhibit "A"

Statement of Assets and Liabilities

March 20, 1956

ASSETS

CURRENT ASSETS			
Cash:			
Atlantic National Bank—Checking A/c	$ 64,787.07		
Florida National Bank—Checking A/c	9,552.36		
Atlantic National Bank—Savings A/c	9.17		
Barnett National Bank—Savings A/c	1,999.44		
Petty Cash	25.00	$ 76,373.04	
Accounts Receivable:			
Due from County Societies—Dues	$44,840.00		
Due from Journal Advertisers	1,973.90	46,813.90	
Inventory—Stationery, Etc.		3,319.26	
TOTAL CURRENT ASSETS			$126,506.20
INVESTMENTS			
U. S. Savings Bonds		$ 29,840.50	
U. S. Treasury Bonds		16,155.37	45,995.87

FIXED ASSETS

	COST	ACCUMULATED DEPRECIATION	BOOK VALUE	
Land	$ 34,716.31	$	$ 34,716.31	
Building—In Progress	44,125.07		44,125.07	
Furniture & Fixtures—General Fund	15,470.88	6,736.79	8,734.09	
Furniture & Fixtures—Public Relations Fund	6,072.51	2,229.25	3,843.26	
	$100,384.77	$ 8,966.04		91,418.73
TOTAL ASSETS				$263,920.80

LIABILITIES AND NET WORTH

CURRENT LIABILITIES	
Reserve for Deferred Income	$ 46,813.90
NET WORTH	
Balance—3/20/'56—Per Exhibit "D"	217,106.90
TOTAL LIABILITIES AND NET WORTH	$263,920.80

Exhibit "B"

Statement of Receipts and Disbursements

March 21, 1955 Through March 20, 1956

BALANCES—March 21, 1955

Atlantic National Bank—Checking A/c		$106,477.55	
Florida National Bank—Checking A/c		23,151.42	
Atlantic National Bank—Savings A/c		9.17	
Barnett National Bank—Savings A/c		1,979.61	$131,617.75

RECEIPTS

Back Dues	$ 35,120.00		
Current Dues	60,560.00		
Entrance Fees	2,590.00	$ 98,270.00	
Interest:			
U. S. Treasury Bonds	$ 1,000.00		
Savings Accounts	19.83	1,019.83	
Miscellaneous Income		911.63	
Advertising—Journal	$ 25,103.53		
—Directory	530.00	25,633.53	
Journal Subscription & Sales		582.23	
Directory Sales		2,080.00	
Technical Exhibits		15,650.00	
Patio Party Tickets		950.50	
Reprints—Non Member		270.00	
TOTAL RECEIPTS			145,367.72
TO BE ACCOUNTED FOR			$276,985.47

DISBURSEMENTS

Administrative:		
Postage and Express	$ 1,439.43	
Office Supplies	1,585.44	
Telephone & Telegraph	1,107.78	
Travel Expense—Managing Director & Department Heads	1,468.11	
Delegates to A.M.A. (3)	1,154.00	
Office Rent	4,044.00	
Maintenance—Office Equipment	323.03	
Blue Cross & Blue Shield (Ass'n Employees)	241.80	
Federal Tax	689.24	
State Sales Tax	993.10	
Federal Excise Tax	69.37	
Furniture & Fixtures	1,994.84	
Books, Pamphlets, Etc.	486.17	
Payrolls	32,242.45	
Contractor Fees	3,612.50	
Reprints—Non Member	216.00	
Employee Pension Trust Plan—Premium	5,176.11	
Employee Pension Trust—Trustee Fee	50.00	
Permanent Quarters	78,841.38	
Journal Printing and Paper	25,253.30	
Drayage	185.15	
Printing, Photography and Engraving	1,848.49	
Directory Printing, Etc.	2,390.10	
Convention Expense	3,760.60	
Miscellaneous Committee Expense	939.00	
Patio Party	1,790.40	
Dues:		
Conference of Presidents	150.00	
Medical Society Executive Conference	5.00	
Rotary Club	145.77	
Attorney's Fee—Insurance Hearings	500.00	
Bank Exchange	4.02	
Christmas Party—Staff	47.61	
Contributions—Miami Student Medical Ass'n	300.00	
Employer's Liability Insurance	58.77	
Floral Arrangements	42.05	
Miscellaneous	32.55	
Porter Service	3.45	
Rental—Safety Deposit Box	12.50	
Treasurer's Bond	225.00	
TOTAL DISBURSEMENTS—ADMINISTRATIVE		$173,428.51

Bureau of Public Relations:			
Postage and Express	$ 1,063.27		
Office Supplies	1,036.93		
Payrolls	12,636.50		
Contractor Fees	60.00		
Blue Cross & Blue Shield (Ass'n Employees)	78.00		
Telephone & Telegraph	1,207.74		
Travel Expense—Supervisor & Assistant	3,655.56		
Federal Tax	345.80		
State Sales Tax	109.79		
Federal Excise Tax	23.87		
Furniture and Fixtures	880.68		
Office Rent	1,932.26		
Books, Pamphlets, Etc.	256.30		
Printing and Engraving	999.37		
Maintenance—Office Equipment	150.08		
Legislation, Public Policy	215.00		
Special Projects	2,195.67		
Dues:			
Chamber of Commerce Membership	100.00		
The Exchange Club	134.80		
Florida Press Association	25.00		
Medical Society Executive Conference	5.00		
Insurance—Liability—Equipment	48.30		
Comprehensive & Liability Auto Insurance—Employees	31.15		
Porter Service	17.85		
TOTAL DISBURSEMENTS—BUREAU OF PUBLIC RELATIONS		27,208.92	
TOTAL DISBURSEMENTS			200,637.43
BALANCE—March 20, 1956			$ 76,348.04
BALANCE COMPRISED OF:			
Atlantic National Bank—Checking A/c		$ 64,787.07	
Florida National Bank—Checking A/c		9,552.36	
Atlantic National Bank—Savings A/c		9.17	
Barnett National Bank—Savings A/c		1,999.44	$ 76,348.04
RECAPITULATION			
Total Disbursements	$200,637.43		
Total Receipts	145,367.72		
Excess Disbursements Over Receipts	$ 55,269.71		

Exhibit "C"

Schedule of Investments

As of March 20, 1956

	Date Purchased	Maturity Date	Face Value	Number of Bonds	Cost	Redemption Value 3/20/'56
U. S. SAVINGS BONDS	11/1/42	11/1/54	25.00	6	$ 111.00	$ 150.00*
"	12/1/42	12/1/54	25.00	2	37.00	50.00*
"	2/1/43	2/1/55	25.00	1	18.50	25.00*
"	3/1/43	3/1/55	25.00	1	18.50	25.00*
"	4/1/43	4/1/55	25.00	2	37.00	50.00*
"	5/1/43	5/1/55	25.00	1	18.50	25.00*
"	11/1/42	11/1/54	1,000.00	2	1,480.00	2,000.00*
"	12/1/42	12/1/54	1,000.00	1	740.00	1,000.00*
"	3/1/43	3/1/55	1,000.00	1	740.00	1,000.00*
"	7/1/43	7/1/55	1,000.00	1	740.00	1,000.00*
"	7/1/43	7/1/55	5,000.00	1	3,700.00	5,000.00*
"	3/1/48	3/1/60	5,000.00	4	14,800.00	17,220.00
"	4/1/43	4/1/55	10,000.00	1	7,400.00	10,000.00*
Total—U. S. Savings Bonds					$ 29,840.50	$ 37,545.00
U. S. TREASURY BONDS	3/20/54	1962-67	1,000.00	1	$ 978.44	$ 1,000.00
"	3/20/54	1967-72	5,000.00	3	15,176.93	15,000.00
Total—U. S. Treasury Bonds					$ 16,155.37	$ 16,000.00
TOTAL INVESTMENTS					$ 45,995.87	$ 53,545.00

* MATURED.

Exhibit "D"
Schedule of Changes in Net Worth
From March 21, 1955 Through March 20, 1956

BALANCE—March 21, 1955			$191,073.04
Add:			
Fixed Assets Capitalized:			
Land	$34,716.31		
Building	44,125.07		
Furniture & Fixtures	2,875.52	$ 81,716.90	
Increase in Stationery Inventory		984.15	
Total		$ 82,701.05	
Less:			
Excess Disbursements over Receipts—Exhibit "B"	$ 55,269.71		
Depreciation (Non-Cash)	1,397.48	56,667.19	
Total			26,033.86
BALANCE—March 20, 1956—To Exhibit "A"			$217,106.90

Exhibit "E"
Dues and Entrance Fees Collected March 21, 1955 Through March 20, 1956

Name of Society	Total Members	No. Paid Members	No. In Arrears	1956 Dues Collected	Back Dues Collected	Entrance Fees
Alachua	55	46	9	1,560.00	360.00	30.00
Bay	27	2	25		280.00	20.00
Brevard	41	31	10	1,000.00	1,240.00	170.00
Broward	141	133	8	4,960.00	1,200.00	230.00
Columbia	11	11	0	240.00		
Dade	739	52	687	200.00	10,680.00	620.00
DeSoto-Hardee-Highlands-Glades	27	5	22		160.00	10.00
Duval	309	178	131	5,440.00	10,520.00	270.00
Escambia	106	95	11	3,360.00	640.00	20.00
Franklin-Gulf	6	6	0	200.00		
Hillsborough	200	164	36	5,920.00	2,160.00	180.00
Indian River	10	10	0	320.00		10.00
Jackson-Calhoun	18	17	1	600.00		10.00
Lake	36	30	6	1,000.00	200.00	70.00
Lee-Charlotte-Collier-Hendry	41	36	5	1,320.00	120.00	70.00
Leon-Gadsden-Liberty-Wakulla-Jefferson	66	57	9	1,960.00	280.00	20.00
Madison	8	5	3	160.00	80.00	
Manatee	30	23	7	760.00	360.00	30.00
Marion	31	25	6	800.00	640.00	10.00
Monroe	14	7	7	200.00	200.00	20.00
Nassau	10	10	0	320.00		
Orange	201	175	26	6,520.00	1,720.00	140.00
Palm Beach	148	132	16	4,800.00	960.00	100.00
Pasco-Hernando-Citrus	18	15	3	440.00	80.00	20.00
Pinellas	239	232	7	8,520.00	400.00	200.00
Polk	110	98	12	3,560.00	400.00	160.00
Putnam	10	9	1	240.00		
St. Johns	21	19	2	640.00		10.00
St. Lucie-Okeechobee-Martin	26	19	7	720.00	320.00	30.00
Sarasota	63	61	2	2,240.00	400.00	50.00
Seminole	20	17	3	600.00		10.00
Suwannee	11	4	7	40.00	400.00	30.00
Taylor	5	4	1	80.00	160.00	10.00
Volusia	86	54	32	1,840.00	1,160.00	40.00
Walton-Okaloosa	21	5	16			
Washington-Holmes	4	1	3			
Totals	2,909	1,788	1,121	60,560.00	35,120.00	2,590.00

Dues Not Payable				
Co. Soc. Secys.	35		35,120.00	Back Dues Collected
Life	107			
Excused	34		95,680.00	Total Dues Collected
Honorary	75		2,590.00	Entrance Fees Collected
Military Serv.	23	274		
			98,270.00	Dues and Entrance Fees
Paying Dues		1,514		

Report of Editor of The Journal
Shaler Richardson, M.D.

This is the first year The Journal of the Florida Medical Association has been published as an activity of the Department of Publications of the Association.

Numerous changes have been made in The Journal this past year, mainly in format and make-up. All of them have added to the attractiveness and readability of the publication.

First is the Table of Contents page. Here the style of type has been changed and the page given a new layout. Second is the type style of the titles of Scientific Papers. This has been changed from an old style to one more modern adding greatly to the attractiveness of the first page of each paper.

Third is the Officers and Committees pages. It was believed these pages should be placed near the other pages providing information about Association affairs in order to complete the section. Also, it was our opinion that the pages should be made as readable as possible because they often are referred to when information about committees is needed. Therefore, a new layout was prepared, the type style changed and the pages moved near to the page that lists the names of county society presidents and secretaries.

Fourth is the Index to Advertisers. This listing was begun as a result of a suggestion advanced during the State Medical Journal Conference held at Chicago. The need for the Index was made evident by advertisers who had expressed a desire for some method of finding their advertisements quickly.

The latest change deals with the legends or captions used underneath each illustration. It was brought out at the State Medical Journal Conference that type used in most journals is too small and therefore difficult to read. Acting from this idea, our caption type was made larger and changed to a more modern style.

During the past year, 51 scientific papers were published of which 43 were written by members of the Association. Fourteen of the papers published, nine by members and five by guest speakers, were read at the 1955 annual meeting in St. Petersburg. Eight of the papers were read before specialty group meetings during the annual convention in St. Petersburg.

This year, 55 abstracts of articles written by Association members for other medical journals were published in The Journal. The staff scans other journals for papers written by members, however it is possible that some papers may have been missed. It is hoped that these members will send us reprints of their papers in order that abstracts may be prepared.

The editorial and commentary section has remained outstanding. Beginning with the July issue, an explanation of the Association's public relations program was published in five installments corresponding to the five principal phases of the program. For the October issue, Dr. Webster Merritt contributed "Physicians and Medicine in Early Alachua County, Part II—War and Pestilence," another in his outstanding series of articles on the history of medicine in Florida.

In December, Dr. Frank G. Slaughter again graciously contributed an article in keeping with the holiday season. Its title this year was "A Physician's Prayer." The editorial "Therapeutics—For Whom?" by Assistant Editor Joseph J. Lowenthal drew commendation from as far away as New England. In February, it was our privilege to publish the announcement of the construction of the Association's permanent home.

Members are urged to send contributions for State News Items, and each Society is requested to place The Journal on its list to receive announcements of regular monthly meetings. These two features are of interest and can be made even more informational with the cooperation of each member and each county medical society.

Our sources of information such as county society bulletins, newspaper clippings and communications from members provide some news, but often the smaller societies have to be passed up because we have no way of knowing what their members have been doing. Especially, these societies are urged to send us notices of their meetings and information of news value about their individual members.

The sections on State Board of Health; Others Are Saying; Books Received; Births, Marriages and Deaths; Obituaries; Medical Licenses Granted, and Woman's Auxiliary continue to be of interest to many readers.

For the section Others Are Saying, we have been publishing articles taken from our county society bulletins as well as those from other medical journals. It is our opinion that Association members are interested primarily in what other members are saying on current topics of interest to the medical profession.

Again this year, I wish to express sincere appreciation to the Assistant Editors, Drs. Webster Merritt and Franz H. Stewart, and to the Associate Editors, Drs. Louis M. Orr, Joseph J. Lowenthal, Jere W. Annis, Herschel G. Cole, Wilson T. Sowder, Carlos P. Lamar and Walter C. Payne Sr.

To Drs. Chas. J. Collins and James N. Patterson, who have served with me on the Committee on Publications, I also express my sincere appreciation. One or both of them have read and approved each scientific paper published in The Journal before it was referred to me. They have given unstintingly of their time and talents, and I know each member of the Association joins with me in an expression of gratitude to them.

Dr. Kenneth A. Morris, Chairman, and his assistant, Dr. Walter C. Jones, are responsible for the smooth functioning of the Abstract Department. I am greatly indebted to them.

Mrs. Edith B. Hill, Editorial Consultant, has rendered valuable service to The Journal during the year as she has for many years. Many Journal authors have utilized Mrs. Hill's talent and realize how fortunate we are to have on the staff an able professional medical writer whose services cover all the refinements of medical journalism.

I wish to express sincere appreciation to Mr. Ernest R. Gibson, Managing Editor of The Journal, who directs the work of actual publication. He has labored to maintain the high standards set for The Journal and at the same time to strive for progress.

Although only in its first year the efficiency and effectiveness of the new Department of Publications has already demonstrated the wisdom of the reorganization. No small part of this success must be credited to Mr. Tom Jarvis in his capacities as head of this Department and as Assistant Managing Editor. He is ably assisted by Mrs. Louise Rader, journal technician. It is pleasantly surprising what is being accomplished by two conscientious and dedicated staff members.

It has been my privilege to be Editor of The Journal for 28 years. I appreciate the confidence the members of the Association have manifested in me by reelecting me year after year, and it is gratifying to know that I have had a part in the growth of The Journal. However, The Journal belongs to the members of the Association and it reflects them. I would urge you to make your suggestions known, and together with The Journal staff strive to make this reflection something of the great medical progress we have seen in the state.

Respectfully submitted,
Shaler Richardson, M.D., *Editor*

Francis Howard Langley, M.D.
President 1956-1957

The Journal of the Florida Medical Association

OWNED AND PUBLISHED BY FLORIDA MEDICAL ASSSOCIATION
P. O. Box 1018 Jacksonville, Florida

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Francis Howard Langley, M.D., President

Dr. Francis Howard Langley was born in Cumberland, Ohio, on Oct. 23, 1899. He received his academic schooling in his native state and was awarded the degree of Bachelor of Arts by Ohio Wesleyan University in 1922. The Johns Hopkins University School of Medicine conferred upon him the degree of Doctor of Medicine in 1926, and for three years thereafter he served successively as intern, assistant resident and resident at the Hospital for Women of Maryland in Baltimore. His fraternities are Phi Beta Kappa, Phi Delta Theta and Alpha Kappa Kappa.

Since locating in St. Petersburg in December 1929 to engage in the practice of general surgery, Dr. Langley has been prominent in local, county and state medical activities. He is a former Chief of Staff at St. Anthony's Hospital and a former Chief of Surgery at Mound Park Hospital, and is a member of the attending staff at both hospitals. In 1949 he was President of the Pinellas County Medical Society. He is a former chairman of the Medical Committee for Better Government of the First Congressional District.

Active in the Florida Medical Association for 27 years, Dr. Langley has served in various official capacities. In 1950 and again in 1955 he was a member of the Board of Governors. In 1952 he held the office of First Vice President. He served in 1954 as Chairman of the Council, and in 1955 he was President-Elect.

Dr. Langley is a fellow of the American College of Surgeons and a member of its Florida Council. He is also a fellow of the Southeastern Surgical Congress and holds membership in the American Medical Association. He has contributed a number of articles to medical literature.

In World War II Dr. Langley had a distinguished record as a lieutenant colonel serving with the First and Third Armies. He was Chief of Surgery at an Evacuation Hospital in Europe and was decorated with five battle stars, the Bronze Star and the Victory Medal. He also served as Chief of Surgery at the Station Hospital at Camp Croft, in South Carolina. He was released from active duty in the grade of colonel, which rank he still holds.

Locally, Dr. Langley is active in civic and fraternal organizations. He is a thirty-second degree Scottish Rite Mason and a Shriner, a member of Egypt Temple. A member of the American Legion, he also holds membership in the Chamber of Commerce, Lions Club, St.

Petersburg Yacht Club, and Sunset Country Club. Since 1931 he has been a trustee of Christ Methodist Church.

Dr. Langley and Mrs. Langley, the former Miss Sarah Graham Hall of Charlotte, N. C., have two sons and two daughters, Ann Carter, James Nelson, Peter and Elizabeth Hall, all of St. Petersburg.

1956 Annual Meeting in Retrospect

The House of Delegates of the Florida Medical Association acted favorably on numerous constructive measures which came before it at the Eighty-Second Annual Meeting, held at the Hotel Fontainebleau in Miami Beach on May 14, 15 and 16. Particularly notable was the enthusiastic approval given the proposed group disability insurance plan, making it now an officially sponsored project of the Association. This action marks the culmination of the long and arduous effort of the Committee on Medical Economics to produce a comprehensive plan, both sound and flexible, which will have strong appeal to the members. This program merits the prompt cooperation of every member. To make it the outstanding success that it promises to be, each eligible member will wish to take advantage of this unusual offer now during the initial enrolment period and thus expedite the operation of the program, which is dependent upon 60 per cent participation.

In approving the principle of the fluoridation of public water supplies, the House enabled the Association to join the American Medical Association and many state and county medical societies in favoring this public health measure. Since in Florida there are varying amounts of fluoride in the water and since it is a function of the Florida State Board of Health to approve water supplies, the resolution as adopted specified that this board determine the appropriate total fluoride concentration.

A movement to establish a network of poisoning control centers throughout the state won approval. Sponsored by the Florida Chapter of the American Academy of Pediatrics and the Florida Pediatric Society, this program seeks to combat the surprisingly high and increasing incidence of cases of poisoning in Florida. The proposed centers would accumulate and disseminate information, dealing with treatment, prevention, and the gathering of data on poisons peculiar to this area.

Changes in the By-Laws were made to provide for permanent committees on Blood and on Nursing. The Committee on Blood is charged with keeping the members of the Association informed on the subject of blood banks and their activities. It will advise local societies and the delegates to the American Medical Association, stress adequate blood collection and distribution in times of emergency, and maintain close cooperation with the Joint Blood Council in Washington. The duties of the Committee on Nursing are to serve in an advisory capacity to state and local Professional Advisory Councils for Practical Nurses and the Professional Nurses' Association regarding problems pertaining to all phases of nursing. In fulfilling its liaison role it will keep the members of the Association abreast of major trends and problems in nursing and nursing education.

The establishment of a State Physicians Committee on Blue Shield was approved. It is to be composed of 16 members, two from each of the eight Councilor Districts, to be appointed by the President of the Association for specified terms, and one physician at large, with the chairman designated annually by the Association's President. This body will serve as a reference committee and advisory to Blue Shield.

The House also gave approval to a recommendation in the report of the Committee on Representatives to Industrial Council that a liaison committee of three physicians be appointed to meet with three representatives of the insurance industry to adjudicate differences regarding fees.

It is noteworthy that the Grievance Committee reported the smallest number of complaints since the Committee was organized, a fact which reflects favorably on the expeditious management of its affairs in the past and bespeaks credit to the local county grievance committees for the manner in which they are satisfying complainants at the local level. The new chairman of this Committee is Dr. David R. Murphey Jr., of Tampa. He succeeds Dr. Herbert E. White, of St. Augustine, who was retired automatically since the Committee is composed of the last five living past presidents of the Association.

An action of the Board of Governors establishing an Executive Committee within the Board met with House approval. This committee was recommended by President John D. Milton, who envisioned many responsibilities for it, particularly long range planning.

Dr. Hunter B. Rogers of Miami, president of the Dade County Medical Association, presents a scroll to Dr. John D. Milton in recognition and appreciation for "his superior service and generous contributions" as president of the state association. The presentation took place during the second session of the House of Delegates.

Provision was made for reimbursing the President and the Secretary of the Association, or their designated representatives, up to a stipulated maximum amount for expenses incurred in travel on Association business. The Board of Governors was authorized to establish a fund for this purpose in the budget and also to continue its study relating to expenses for other officers and committee chairmen.

Another item ordered set up in the budget was a sum, not to exceed $300 in each instance, to be used in helping defray the expenses of one representative from each of the two medical schools in Florida to the annual meeting of the Student American Medical Association. The contribution of equal amounts to these schools for this purpose was a recommendation of President Milton, whose comments in his presidential address on training the medical students of today to become the physicians of tomorrow are thought-provoking and merit careful perusal.

The Board of Governors was directed to take the necessary steps to establish a Florida medical foundation, to be controlled and administered by the Association. The purpose of this foundation is to promote better medical care in Florida. A suitable name for the organization has not yet been chosen.

Among the numerous resolutions approved by the House was one proposing a constructive mental health program which included taking the necessary steps toward having the office of Com-

missioner of State Mental Institutions established. Others were a resolution opposing advertising on prescription forms, and one instructing the Committee on Legislation and Public Policy to study the problem of advertising and devise means which will prohibit improper and misleading advertising by any licensed member of the healing arts in Florida. Still another was one aimed at procuring for Florida a better driver's license law. The complete proceedings, covering in detail all legislation, are published elsewhere in this issue of The Journal.

The scholarly address of retiring President Milton, also published in the July Journal, is both stimulating and forthright in its presentation of today's problems and responsibilities confronting the medical profession, individually and collectively. His portrayal of the dangers posed by the corporate practice of medicine is as timely as is his reminder to the individual practitioner that if he "does not have in his heart the desire to associate with his colleagues in a gentlemanly fashion, all of the principles and codes which we could design would be to no avail." Every member of the Association will find his message good medicine — a worthy incentive to protect the precious heritage of "The Private Practice of Medicine."

A notable feature of the meeting was approval by the House of the Code of Cooperation adopted a few days earlier by the Florida Bar. Addressing the delegates, President Lazonby of the Bar said: "The big problem that we have, the deepest issue of our time, is whether our people in this country can and will maintain a free society. To maintain a free society it is imperative that leadership be furnished by the learned professions, which require training in objective thinking. Notwithstanding the lofty aims and spirit of public service on which each of our professions is grounded, it is basic that the leadership it exerts can be effective only to the extent that society accepts that leadership, and that, gentlemen, is a point that we should keep in mind constantly. We have commenced a wonderful and interdependent relationship based on mutual need, but also on mutual responsibility to society, and I have the feeling that in the future together we will accomplish a great deal."

The Association was honored by the presence of Dr. John R. Fowler, of Barre, Mass., the immediate past president of the American Academy of General Practice, who addressed the House briefly. Distinguished guest essayists were Dr. Shields Warren, of The Harvard Medical School, Boston, Dr. James J. Callahan, of the Stritch School of Medicine, Loyola University, Chicago, and Dr. Lauren H. Smith, of The Institute, Pennsylvania Hospital, Philadelphia.

At the closing session of the House, Dr. Francis H. Langley, of St. Petersburg, was installed as President, succeeding Dr. Milton, of Miami. Dr. William C. Roberts, of Panama City, was chosen President-Elect. Other officers elected were Dr. Meredith Mallory, of Orlando, First Vice President; Dr. Kenneth A. Morris, of Jacksonville, Second Vice President, and Dr. Cecil M. Peek, of West Palm Beach, Third Vice President. Dr. Samuel M. Day, Secretary-Treasurer, and Dr. Shaler Richardson, Editor of The Journal, both of Jacksonville, were re-elected, Dr. Day for the sixth term and Dr. Richardson for the twenty-ninth.

The attendance was the highest ever recorded. There were 1,164 physicians registered and a total registration of 2,091. The Hollywood Beach Hotel, in Hollywood, was the official choice of a place for the 1957 convention, and the dates set by the Board of Governors are May 5 to 8. Jacksonville was selected as the site of the 1958 meeting provided additional hotel facilities now in the planning stage are available.

Florida Medical Association Golf Tournament

The Florida Medical Association Golf Tournament, an annual affair taking place concurrently with the Convention, was held at the Normandy Isle course on Miami Beach. The names of the winners were announced and prizes awarded at the Association's annual dinner on Tuesday evening, May 15.

The Orlando Loving Cup for low net score was won by Dr. Arthur A. Weiland, of Coral Gables. Dr. Julian A. Rickles, of Miami, won the Duval County Medical Society Trophy for low gross.

Members of the Woman's Auxiliary to the Florida Medical Association held their annual tournament at the same time. Play resulted in a tie between Mrs. David Brezin and Mrs. Lester A. Russin, both of Miami Beach. In the play off, Mrs. Russin was declared the winner.

Dr. Rickles was chairman of the Golf Committee. Assisting him were Drs. Mathew W. Kobak, Richard E. Strain, Donald G. Stannus and Leo M. Levin, all of the Miami area.

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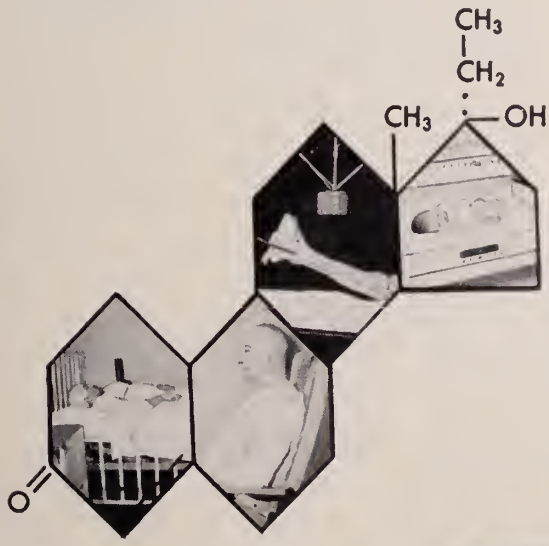

OBJECTIVE AND SUBJECTIVE RESPONSE—Orally effective, Nilevar therapy is characterized by retention of nitrogen, potassium, phosphorus and other electrolytes in ratios indicative of protein anabolism. Moreover, subjectively the patient observes an increase in appetite and sense of well-being.

WELL TOLERATED—Nilevar has an extremely low toxicity. Laboratory animals fail to show toxic effects after six months of continuous administration of high dosages. Nilevar should not be administered to patients with prostatic carcinoma. Nausea or edema may be encountered infrequently. Slight androgenicity may be evidenced on high dosage or in particularly responsive individuals.

MAJOR INDICATIONS—Preparation for and recovery from surgery; supportive treatment of serious illnesses (pneumonia, poliomyelitis, carcinomatosis, tuberculosis); recovery from severe trauma and burns; decubitus ulcers; care of premature infants.

DOSAGE—The daily *adult* dose is three to five Nilevar tablets (30 to 50 mg.) but up to 100 mg. may be administered. For *children* the average daily dose is 1 to 1.5 mg. per kilogram of body weight; individual dosages depend on need and response to therapy.

SUPPLY—Nilevar is available in uncoated, unscored tablets of 10 mg. G. D. Searle & Co., Research in the Service of Medicine.

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SEARLE

Invitation to Participate In Pan American Eye Specialists 1957 Congress in New York

Eye specialists from all the countries of the Western Hemisphere will gather in New York City, April 7-10, 1957, at the Hotel Statler, for the Fourth Interim Congress of the Pan American Association of Ophthalmology, according to an announcement by Dr. Brittain F. Payne, New York, President of the Association. The Congress will be held in conjunction with the annual meeting of the National Society for the Prevention of Blindness.

Three official subjects, to be discussed by invited speakers, have been selected. These are: Diseases of the Ocular Fundus; Ophthalmic Surgery; and Therapeutics in Present-Day Ophthalmology. "Free" papers on other topics may be included in the program so far as time allows. Dr. John M. McLean, Professor of Clinical Surgery in Ophthalmology, Cornell Medical College, New York, is chairman of the program committee. Those who wish to present papers are invited to communicate with Dr. McLean at the New York Hospital, 525 East 68th Street, New York 21, N. Y.

A cinema program relating to the three official subjects is being planned under the chairmanship of Dr. Wendell L. Hughes, Professional Building, Hempstead, N. Y. Ophthalmologists who have suitable films should write to Dr. Hughes. There will also be a number of interesting exhibits.

Dr. Conrad Berens, former President of the Association, and Dr. Algernon B. Reese, Chairman of the Fellowship Committee, both of New York, are serving as consultants on plans for the Congress.

Dr. Payne advised that ophthalmologists planning to attend the Congress make their reservations with the Hotel Statler direct.

Ford Foundation Program of Matching Grants

Heartening to the medical profession in general, and particularly to the many physicians in Florida and across the nation who have worked diligently for the American Medical Education Foundation, is a recent announcement of the Ford Foundation. A $10,000,000 program of matching grants to the National Fund for Medical Education is planned over a five to 10 year period with a maximum limit in any one year of $2,000,000. With the grants paid on a sliding scale, this program could last up to 10 years, but might be accelerated to completion in five years, depending on the rate at which additional contributions are developed.

The National Fund, which distributes monies raised by the American Medical Education Foundation along with contributions from industry and the general public, received last year $2,147,000 in unearmarked funds for distribution to the nation's medical schools. Of this amount, $422,812 came from the medical profession through the American Medical Education Foundation. If these receipts are of equal magnitude in 1956, under the Ford Foundation formula a Ford grant totaling 70 per cent of this amount, or $1,503,486, would be made. All contributions in excess of the 1955 total would be matched dollar for dollar, subject to the annual maximum of $2,000,000.

In announcing the grant, President H. Rowan Gaither of the Ford Foundation said: "The Ford Foundation is aware of the critical needs of the nation's medical schools and of the threat to the national welfare posed by their current plight. . . . The Foundation hopes that grants under this appropriation will assist in efforts to stimulate the interest and response of the medical profession and of the general public, to the end that financial

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support for medical schools can be maintained at a level consistent with sound medical education."

This welcome news is especially gratifying to physicians who have given to the medical schools through the American Medical Education Foundation. It means that for every unearmarked dollar contributed through this channel, another 70 cents to a dollar will be given by the Ford Foundation, thereby stimulating additional financial support of which the nation's medical schools stand in dire need. Every dollar given in 1956 above last year's gifts will mean two dollars for the medical schools. This matching grants program of the Ford Foundation offers a convincing argument not only for continuing but also for increasing contributions to this cause.

1956 Tri-State Obstetric-Pediatric Seminar

The Florida Medical Association and the Florida State Board of Health announce the Sixth Annual Tri-State Obstetric-Pediatric Seminar to be held at the Daytona Plaza Hotel, Daytona Beach, on Sept. 10-12, 1956. An outstanding panel of nationally known physicians in the fields of obstetrics and pediatrics will present papers on subjects of general interest within their respective fields and will also serve as members of a panel to answer and discuss questions submitted by those attending.

Among those who will participate as members of the staff are Dr. Edith L. Potter, Associate Professor of Pathology, Department of Obstetrics and Gynecology, University of Chicago, The School of Medicine; Dr. Clement A. Smith, Associate Professor of Pediatrics, Harvard Medical School; Dr. James G. Hughes, Professor of Pediatrics, University of Tennessee College of Medicine; and Dr. Allan C. Barnes, Chairman of the Department of Obstetrics and Gynecology, Western Reserve University School of Medicine, Cleveland, Ohio.

The Tri-State Obstetric-Pediatric Seminar, which is rapidly gaining wide recognition, is sponsored by the Bureaus of Maternal and Child Health of the Florida, Georgia and South Carolina State Health Departments, and the state medical associations of these three states. All physicians are welcome. There is no registration fee. Programs will be distributed to all physicians at a later date.

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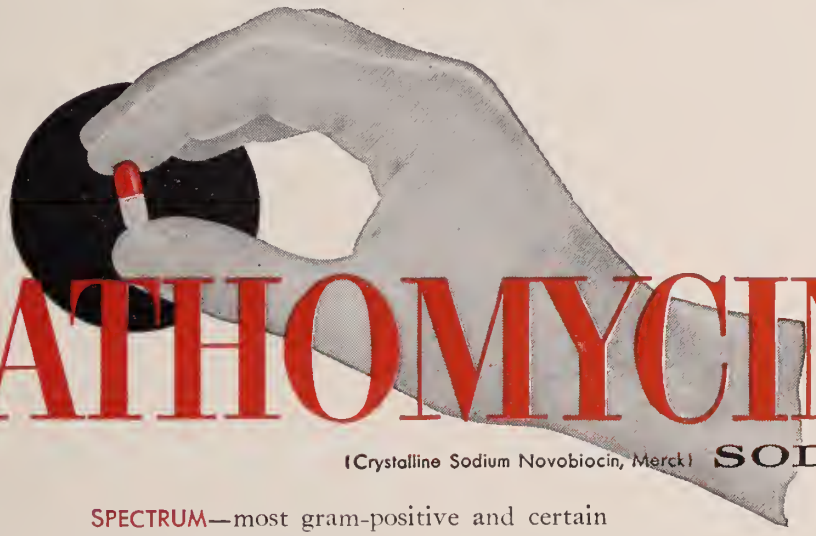

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World Medical Association Havana Meeting October 9-14, 1956

Many Florida physicians will be interested in the forthcoming World Medical Assembly in nearby Havana, Cuba. On October 10, which is Cuban Independence Day, The World Medical Association will hold the opening plenary session of its Tenth General Assembly in that city. This is the first time that an Assembly has been held in Latin America. The only other meeting held in the Western Hemisphere was the 1950 Assembly in New York City.

The 1956 Assembly will begin with a day of registration on October 9, and sessions will continue through October 14. The following day will be devoted to an excursion to Veradero Beach. The morning session on October 11 will give consideration to problems of medical publications in Latin America, and the Scientific Session will be devoted to two main subjects—cardiology and nutrition.

On October 8 and 9, immediately preceding the Assembly sessions, the Latin American physicians will meet jointly with representatives of The World Medical Association and the International Hospital Association to consider ways and means of improving the hospital standards in Latin America.

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*Moyer, J. H., and others: J. Chronic Dis. 2:670, 1955.

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WANTED: Physician with Florida license. Interest in Physical Medicine and Geriatrics. State qualifications in writing. The Miami-Battle Creek, Miami Springs, Fla.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Casten, Gus G., Miami
Corwin, William, Miami
Crawley, Joseph H., Miami
Davis, Charles E., Birmingham, Ala.
Imbus, Harold R., Williston
Isaacson, Marvin G., Miami Beach
Kerman, Herbert D., Daytona Beach
Lary, Banning G., Miami
Lawson, Robert B., Miami
Link, Robert J., St. Petersburg
LoPresti, Gaetano A., Fort Lauderdale

MaCris, Jack A., St. Petersburg
Meyer, Patricia A., Fort Lauderdale
Orebaugh, John E., St. Petersburg
Roberts, Hyman J., W. Palm Beach
Schutt, James B., Fort Myers Beach
Smythe, John W., Winter Haven
Wells, Marion F., St. Petersburg

STATE NEWS ITEMS

Dr. Harold M. Silberman of Coral Gables has returned from Philadelphia where he attended a postgraduate course in chest diseases given by the American College of Chest Physicians.

Dr. E. Sterling Nichol of Miami was one of the principal speakers at the 98th Annual Meeting of the Missouri State Medical Association held recently at St. Louis. The title of his address was "Treatment of Patients with Coronary Atherosclerosis."

Dr. Meredith F. Campbell of Miami discussed "Urologic Problems Frequently Encountered in Children" at the recent Pediatric Seminar of the University of Maryland School of Medicine in Baltimore.

Dr. Julien C. Pate Sr. of Tampa has been appointed to the Crawford A. Long Committee by the Georgia State Medical Association.

Dr. Frank A. Massari of Tampa has been named an Associate in the American College of Physicians.

Dr. Clarence D. Rollins of Jacksonville has returned from an extensive tour of Europe. He attended the International Congress on Obstetrics and Gynecology held at the University of Vienna and inspected various clinics on the continent.

Dr. Ashbel C. Williams of Jacksonville attended the recent annual meeting of the American Cancer Society held in New York City.

Dr. Irvin C. Schneider of Jacksonville has returned from New York City where he attended a Graduate Seminar in Internal Medicine at Presbyterian Hospital.

Dr. N. Stuart Gilbert of Miami Beach has completed a workshop seminar in Ballistocardiographic Technic and Interpretation sponsored by the American College of Cardiology at the Jersey City Medical Center.

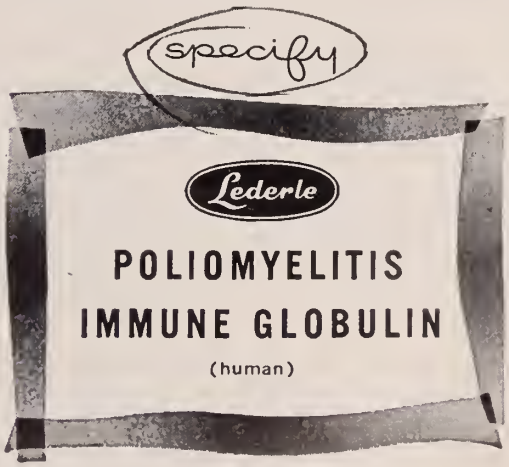
Dr. Raymond H. King of Jacksonville has been elected president of the Jacksonville Historical Society.

The Sixteenth Annual Meeting of the Gulf Coast Clinical Society will be held at the Admiral Semmes Hotel in Mobile, Ala., October 18-19, 1956. An outstanding program is being planned with speakers selected from the faculties of the various medical schools.

Dr. Alvan G. Foraker of Jacksonville has been notified of election to membership in the Society for Experimental Biology and Medicine.

Dr. Charles C. Grace of St. Augustine has returned from Montreal, Canada, where he attended the annual meeting of the American Rhinological, Laryngological and Otological Society.

(Continued on page 92)



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References: 1. Hollander, J. L. *Ann. New York Acad. Sc.* **61**:511, May 27, 1955.

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(Continued from page 89)

Dr. Samuel M. Day of Jacksonville, secretary-treasurer of the Florida Medical Association, was principal speaker at a recent meeting of the Woman's Auxiliary of American Legion Post #137 held in the city.

Drs. Edmund P. Kelley and Carlyle A. Luer of Sarasota were principal speakers at a meeting held recently at the Sarasota Junior High School. Their subject was cancer. The meeting was open to the public but parents of high school students were especially invited.

Dr. W. Ambrose McGee of West Palm Beach discussed "Allergies" at the April meeting of the Parents' Group of the Crippled Children's Society of the city.

Drs. Irwin S. Leinbach and Leonard Freed of St. Petersburg were principal speakers at the Eighth Annual Convention of the Florida Society of X-Ray Technicians held in St. Petersburg the middle of April. Dr. Leinbach addressed a luncheon session on the subject "The Substitution of Metal Joints in the Treatment of Arthritis and Severe Fractures." Dr. Freed spoke at the banquet. The title of his address was "Newer Advents in Medicine in the Atomic Age."

Drs. James A. Sewell and Isabel Roberts of Melbourne appeared on the program of the seminar on cancer held in the Episcopal Parrish House there the middle of April for all registered and practical nurses in the area.

Dr. Leland H. Dame of Winter Park has been appointed physician for the city of Orlando.

Dr. Russell B. Carson of Fort Lauderdale has been reelected president of Blue Shield of Florida, Inc. Other officers reelected at the recent annual meeting held at Miami Beach included Dr. John T. Stage, secretary; Dr. Floyd K. Hurt, treasurer; Dr. Samuel M. Day, assistant treasurer, and Mr. H. A. Schroder, assistant secretary. All are from Jacksonville. Dr. George S. Palmer of Tallahassee and Dr. Hunter B. Rogers of Miami have been elected vice presidents.

Dr. Shaler Richardson of Jacksonville, editor of The Journal of the Florida Medical Association, has returned from Hot Springs, Va., where

a pause for reflection . . . Operation finished. You sit back and relax. Blockain* anesthesia lasted long enough with one small injection so that you were easily able to proceed from incision to closure without pause for reinjection. **Longer anesthetic duration . . .** You did that accurate reapproximation of skin edges without distortion from freshly introduced anesthetic. And more, Blockain persisted post op.—you had no complaints of uncomfortable splints, dressings or tender tissues. **Rapid onset, too . . .** You recall that the pre-incision wait was avoided. *A case to remember:* A 78-year-old patient, arteriosclerotic, poor liver function with a transcervical fracture of left femur, underwent a *one-hour-and-20-minute operation,* involving internal fixation of the fracture and the placement of a Smith-Petersen nail, with *one injection of Blockain.* Effect of anesthetic: "excellent." Onset of anesthesia: "rapid." Only 60 cc. of Blockain was used. A whiff of nitrous oxide was given at the time of actual hammering, to spare the patient emotional trauma. There were no side effects. **BLOCKAIN,** 30 cc., 0.5% (5 mg./cc.). Write GEORGE A. **Breon** & CO., 1450 Broadway, N. Y. 18 for additional information.

2-PROPOXY DERIVATIVE OF 2-DIETHYLAMINOETHYL 4-AMINOBENZOATE.

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he attended the recent 92nd Annual Meeting of the American Ophthalmological Association.

Dr. George D. Lilly of Miami attended the Ogden (Utah) Surgical Association annual meeting as a guest speaker. While there he delivered two addresses on peripheral vascular disease. Following this, he returned to Chicago to preside at the Tenth Annual Meeting of The Society for Vascular Surgery held June 10. Dr. Lilly is president of the Society.

Dr. Sherman B. Forbes, Dr. Hugh E. Parsons and Dr. R. Renfro Duke, of Tampa, Dr. W. Jerome Knauer Sr., of Jacksonville, and Dr. James W. Clover Jr., of Daytona Beach, attended the Fifteenth Clinical Meeting of the Wilmer Residents Association, held at the Wilmer Ophthalmological Institute of The Johns Hopkins Hospital and University in Baltimore, April 19-21, 1956.

Dr. Rothwell C. Polk of Jacksonville began a one year Fellowship in Surgery at the Lahey Clinic in Boston on July 1.

COMPONENT SOCIETY NOTES

Brevard

Dr. Isidore Pincus, of Orlando, was principal speaker for the May meeting of the Brevard County Medical Society. The subject of his address was "Cutaneous Aspects of Internal Medical Diseases."

Dade

A panel discussion on "Radiologic Topics of General Interest" was a feature of the May meeting of the Dade County Medical Association. Members of the panel included Drs. Donald H. Altman, George P. Daurelle and Robert C. Flipse, of Miami, and Dr. James Nesbitt III, of Homestead.

Hillsborough

Dr. Thomas H. Garth, of Tampa, was principal speaker for the May meeting of the Hillsborough County Medical Association. The title of his address was "Bowel Obstruction in Infants and Children."

(Continued on page 98)

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1. Fazekas, J.F., et al.: J.A.M.A. **161**:46 (May 5) 1956. 2. Mitchell, E.H.: J.A.M.A. **161**:44 (May 5) 1956.

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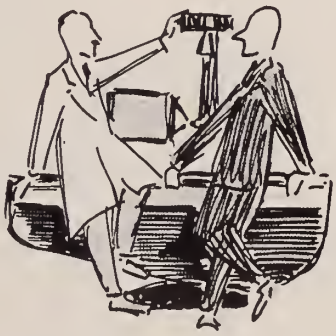

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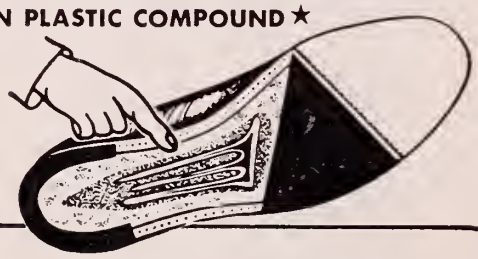

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Foot-so-Port Shoe Company, Oconomowoc, Wis.
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(Continued from page 94)

Jackson-Calhoun

The Jackson-Calhoun County Medical Society has paid 100 per cent of its state dues for 1956.

Lake

Dr. John H. Webb Jr., of Orlando, discussed "The Practical Approach to Everyday Problems Found in the Ear, Nose and Throat" at the May meeting of the Lake County Medical Society. Dr. J. Rocher Chappell, of Orlando, and Captain C. Q. Wright were principal speakers at the Society's April meeting. Their subject was civil defense.

Dr. James R. Cook, of Orlando, spoke to the Society at the June meeting. The title of his address was "Treatment of Nodular Goiter with Radioactive Iodine."

Pinellas

Drs. William R. Tench and David M. Weible of Clearwater were principal speakers on the program for the June meeting of the Pinellas County Medical Society held at the Fort Harrison Hotel in Clearwater. The title of Dr. Tench's address was "Pulmonary Embolism," and Dr. Weible spoke on the topic "The Hand Is Quicker Than the Eye."

According to announcement, July, August and September have been declared vacation months during which time there will be no regular monthly meetings of the Society. However the Board of Governors will convene monthly as usual. The Society's annual meeting is scheduled for October 1.

St. Lucie-Okeechobee-Martin

Dr. Hyman J. Roberts of West Palm Beach addressed a recent meeting of the St. Lucie-Okeechobee-Martin County Medical Society. The title of his address was "A Practical Approach to the Diagnosis of Obscure Illness."

Volusia

Drs. M. Josie Rogers and Charles O. Sayres of Daytona Beach were honored by the Volusia County Medical Society at a May meeting by the presentation of plaques and by a testimonial dinner at the Daytona Plaza Hotel.

Dr. Rogers has practiced at Daytona Beach for 49 years and Dr. Sayres has been a physician there since 1922.

The program for the meeting consisted principally of a recounting by the two physicians of

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capacity is greatly enhanced. "Relief of symptoms is more complete and maintained for longer periods with relatively small doses."[2]

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Supplied: White, 5 mg. oral tablets, bottles of 20 and 100. Pink, 1 mg. oral tablets, bottles of 100. Both deep-scored.

1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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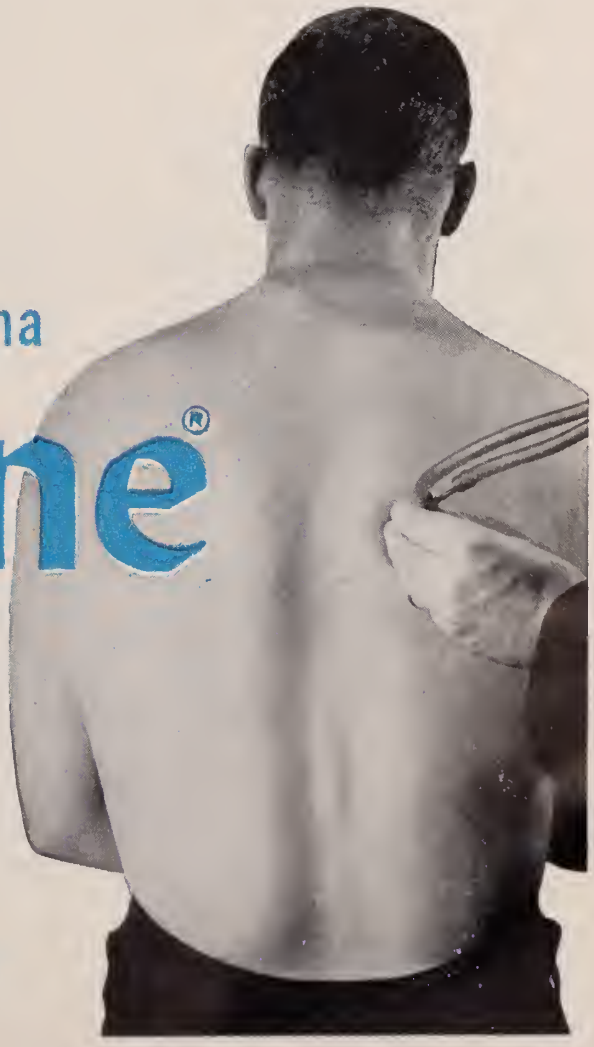

organomercurial diuretics "...permit ingestion of enough salt to make food palatable; without them, many patients would lose their appetites, a consequence of the salt-free diet which has occasionally been known to cause serious malnutrition."*

*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

03156

their experiences in the early days of their practice, and an address by Dr. Alphonsus M. McCarthy of Daytona Beach.

Dr. Rogers, a graduate of Hahnemann Medical College in Chicago, is a former member of the City Commission and served a term as mayor of Daytona Beach. She is a charter member of the Florida State Business and Professional Women's Club, and in 1925 she attended the first International Conference on Child Welfare in Geneva, Switzerland.

Dr. Sayres was graduated from the University of Buffalo School of Medicine and practiced in Allegheny County, New York, for 18 years.

Duval

A panel discussion on the subject "Physicians and Malpractice" was the feature of the June meeting of the Duval County Medical Society.

Representing medicine on the panel was Dr. Samuel M. Day. Mr. Caldwell Haynes, of Jacksonville, presented the insurance aspect of the subject, and Mr. W. M. Howell, also of Jacksonville, the legal aspect.

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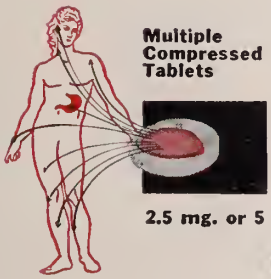

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References: 1. Boland, E. W., *J.A.M.A.* 160:613, February 25, 1956. 2. Margolis, H. M., *et al.* *J.A.M.A.* 158:454, June 11, 1955. 3. Bollet, A. J., *et al.* *J.A.M.A.* 158:459, June 11, 1955.

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TWICE AS MANY FILTERS IN EVERY VICEROY TIP

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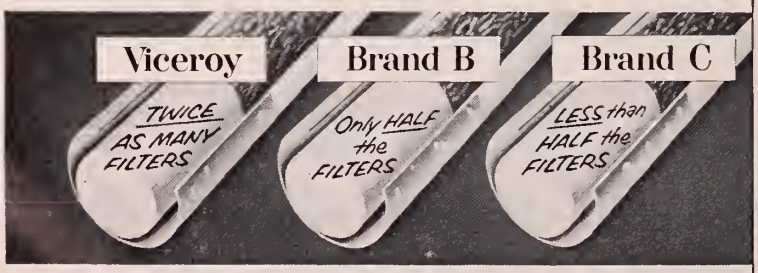

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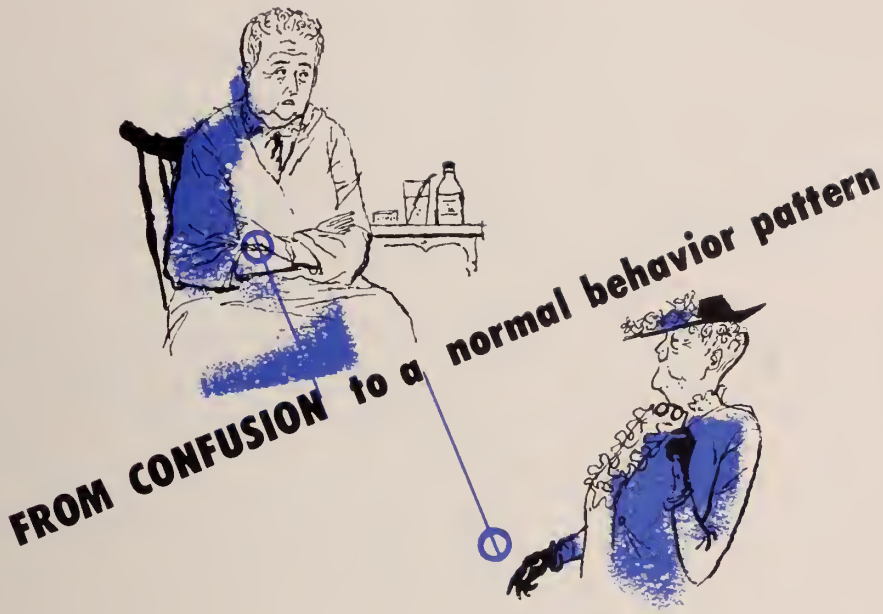

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1. *Levy, S.* J.A.M.A. *153:1260, 1953.*
2. *Thompson, Lloyd & Proctor, Rich.* N. C. State, *Dec. 54*
3. *Thompson & Proctor,* Clinical Med *April, 1956*

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Convention Reports Show Continuing Interest

Under the splendid leadership of the 1955-56 president, Mrs. Samuel S. Lombardo, the officers elected by the delegates to the 1955 convention and the chairmen appointed by Mrs. Lombardo, the Woman's Auxiliary to the Florida Medical Association has shown another year of progress and continuing interest in the program and projects of the Auxiliary.

As of the date of the convention meeting, May 14, membership in the Auxiliary has increased by 55 members, making our total 1,788. This allows Florida 18 delegates and her presidential delegate at the annual meeting of the Woman's Auxiliary to the American Medical Association, and it is expected that 100 per cent delegation will answer the roll call as it has in the past several years.

District A now has 162 members in organized auxiliaries and 15 members-at-large.

District B now has 583 members in organized

(Continued on page 110)

looked over often...

the patient with nonspecific rheumatism

NOW—thoroughgoing relief with

NEW SIGMAGEN TABLETS

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Prednisone	0.75 mg.	—best of the new
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Your patient can add skim milk powder along with the seasonings in meat loaf—then hide hard-cooked eggs inside for a bright-eyed surprise.

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Cottage cheese is happily versatile. It tops any salad—fruit, vegetable, flaked fish. Makes a pleasing spread, too, especially on dark breads. Thinned with milk and mixed with chili sauce, it's a zesty salad dressing. Or a good amount can be whipped into mashed potatoes.

An egg white whipped into fruit juice makes a frothy flip. Or you might suggest gelatin instead.

And a fruit-cheese dessert is a gourmet's delight. Pears go with blue cheese, apples with Camembert, orange sections with cream or cottage cheese.

Even in the budgetwise diet, variety is not only possible but necessary to assure adequate intake of all the essential amino acids. And a glass of beer* along with it can add zest and flavor to the most simple meal.

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Beer—America's Beverage of Moderation

*Protein 0.8 Gm. Calories 104/8 oz. glass (Average of American Beers)

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The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
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(Continued from page 106)

auxiliaries and 4 members-at-large.

District C now has 433 members in organized auxiliaries and 12 members-at-large.

District D now has 570 members in organized auxiliaries and 9 members-at-large.

Altogether Florida has 1,748 members in organized auxiliaries and 40 members-at-large, the greatest number of members-at-large and members in organized auxiliaries we have ever had.

Again for the fourth year, Florida is over the top in the Today's Health project, having 100 per cent as of April 2. Although the report is incomplete, it looks probable that Florida will be over $1.00 per member for the American Medical Education Foundation. At the time of the report, only 12 counties had sent in their money. With these two projects, as with others, it will be necessary for the final report to come later since the fiscal year for the AMA Auxiliary is not ended until June 30.

The state nurse recruitment program has increased by leaps and bounds. At the state meeting in St. Petersburg, March 16-17, 45 Future Nurse Clubs of 51 we have in the state were represented. Some 123 club members and 19 chaperons were housed. A total of more than 400 high school students and sponsors participated in this state-wide Future Nurses Club meeting. Schools of nursing throughout Florida are reporting that more and better equipped applicants than ever before are applying. The total high school students in our 51 clubs is 1,723. Fifteen new clubs were organized this year.

Mrs. Scottie J Wilson
President, Woman's Auxiliary

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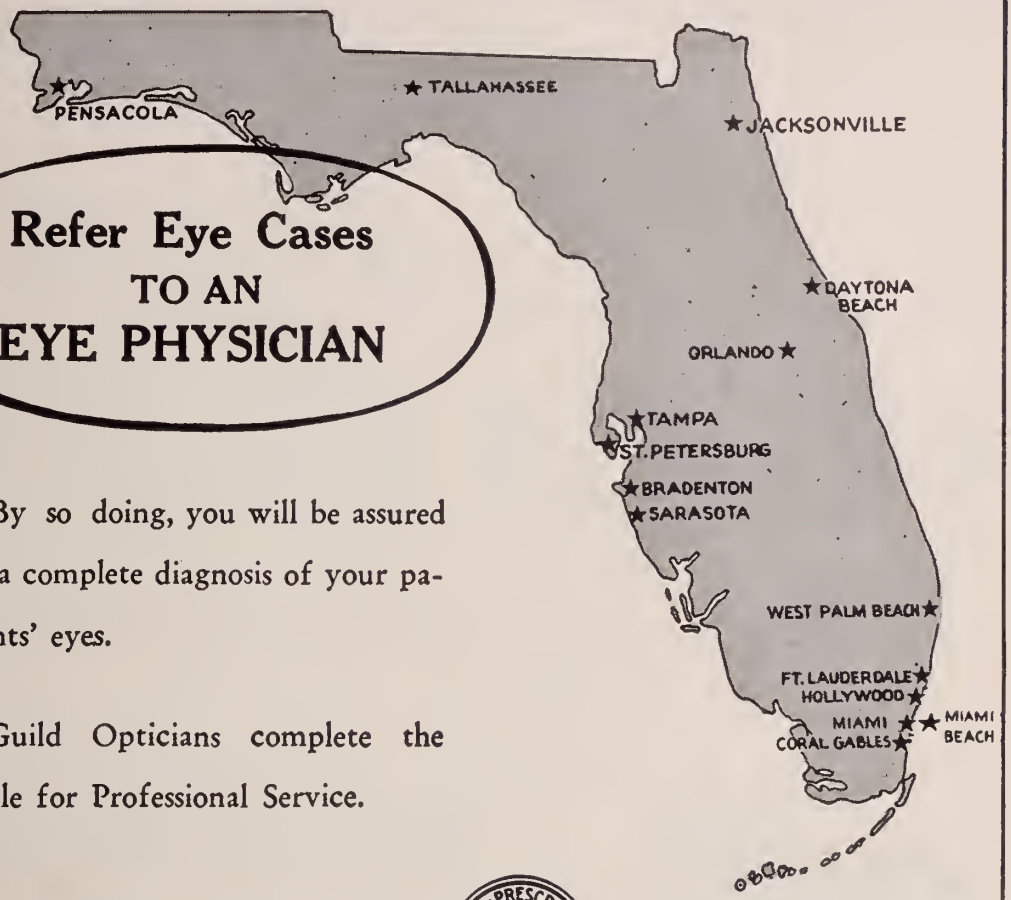

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During 1955-56, $600 was loaned four county auxiliaries who matched this amount ($150 to each auxiliary) in loaning students of nursing funds for their training. Since this fund was implemented in 1951, 23 students have received loans to aid in their nursing education. We are proud of the work we have been able to do in augmenting the number of students for training and also in helping to send deserving students to school. These figures are only from those receiving matching funds from the state and do not reflect the total number receiving help as many have been helped from the county auxiliaries without aid from the state fund.

Approximately 2,500 issues of Medaux, the Florida Auxiliary official publication, were issued each quarter and helped keep the members informed of the state work and what other component auxiliaries were doing. Auxiliary members were kept informed of national legislation and helped to inform legislators when called upon to do so by their local medical societies. The total program of the national and state auxiliaries was carried out by the county auxiliaries and self-information as well as information for the public spearheaded this educational effort. Auxiliary members throughout the state helped in various health agency efforts toward better health for Floridians. On most of the volunteer health agency boards at local and state levels, the doctor's wife is taking her share of the responsibility.

The members-at-large of our Auxiliary were kept informed of all auxiliary activities, and material from state and national auxiliaries were sent them for their self-education. In most counties where we have no organized auxiliary, our members-at-large were working with us for the betterment of health in our state.

It is impossible in one article to give but a general view of what the doctors' wives in Florida have done to aid the medical societies and promote better health in our state. We hope to give more detailed reports during the year — but one thing we can say with pride — "The doctors' wives in Florida, through their auxiliaries, are carrying more than their share of responsibility in the promotion of national and state projects and in their service to their medical societies and their communities in health."

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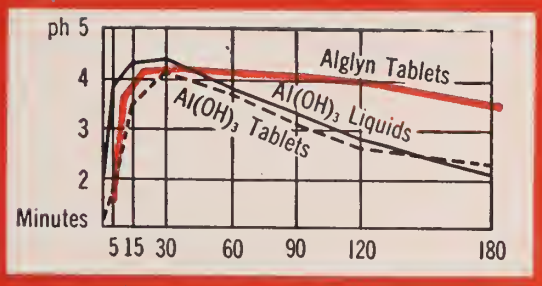

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Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

Reprint of recent in vivo studies available on request

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2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Albert G. Love IV, Gainesville	G. Leonard Emmel, Gainesville	2nd Tues.	56
***Bradford, Gilchrist, Union**				
Bay	Joseph H. Morris, Panama City	John J. Hollomon Jr., Panama City	1st Tues.	29
Brevard	Isabel Roberts, Melbourne	Jack T. Bechtel, Eau Gallie	2nd Tues.	41
Broward	Thomas F. Huey Jr., Fort Lauderdale	Anthony C. Galluccio, Hollywood	4th Tues.	142
Columbia	Thomas H. Bates, Lake City	Clifton G. York, Lake City	1st Mon.	11
***Baker**				
Dade	Hunter B. Rogers, Miami	Vincent P. Corso, Miami	1st Tues.	758
DeSoto-Hardee-Highlands-Glades	Merle C. Kayton, Wauchula	Roland W. Banks, Wauchula	1st Tues.	27
Duval	Joseph J. Lowenthal, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	313
***Clay**				
Escambia	Gretchen V. Squires, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	105
***Santa Rosa**				
Franklin-Gulf	Harold B. Canning, Wewahitchka	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	James N. Patterson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	204
Indian River	Vernon L. Fromang, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	10
Jackson-Calhoun	Richard H. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	18
Lake	Geoffrey H. Binneveld, Leesburg	J. Basil Hall, Tavares	1st Wed.	34
***Sumter**				
Lee-Charlotte-Collier-Hendry	Joseph L. Selden Jr., Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	42
Leon-Gadsden-Liberty-Wakulla-Jefferson	Robert H. Mickler, Tallahassee	Odis G. Kendrick Jr., Tallahassee	Quarterly	71
Madison	Candler K. Hayes, Madison	Wilmer J. Coggins, Madison		8
Manatee	Richard V. Meaney, Bradenton	Eugene E. Biel, Bradenton	2nd Tues.	30
Marion	William J. McGovern, Ocala	Robert L. Gibson, Ocala	3rd Tues.	31
***Levy**				
Monroe	Allen Shepard, Key West	William R. Ploss, Key West	1st Thurs.	14
Nassau			Last Fri.	9
Orange	Thomas C. Butt, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	199
***Osceola**				
Palm Beach	Walter R. Newbern, West Palm Beach	Horace D. Atkinson, West Palm Beach	4th Mon.	149
Pasco-Hernando-Citrus	Gail M. Osterhout, Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	18
Pinellas	Daniel F. H. Murphey, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	248
Polk	James T. Shelden, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	111
Putnam	Bennie J. Massey, Palatka	Bernard E. Kane, Crescent City	2nd Tues.	10
St. Johns	Reuben J. Plant Jr., St. Augustine	Roy E. Campbell, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Alfred J. Cornille, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	26
Sarasota	Eugene D. Liddy Jr., Sarasota	Karl R. Rolls, Sarasota	2nd Tues.	64
Seminole	William V. Roberts, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	Shirley L. Hadden, Live Oak	Hiram B. Curry, Jasper	1st. Sat.	12
***Hamilton, Lafayette**				
Taylor	Ralph J. Greene, Perry	John H. Parker Jr., Perry	Last Fri.	5
***Dixie**				
Volusia	Theodore F. Hahn Jr., DeLand	Achille A. Monaco, Daytona Beach	2nd Tues.	88
***Flagler**				
Walton-Okaloosa	Henry C. White Jr., Fort Walton Bch.	George W. Barrow Jr., Crestview	3rd Tues.	21
Washington-Holmes	Martin L. Lane, Chipley	L. H. Paul, Bonifay		4
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John W. Cline and Philip R. Westdahl

Mental Health in Florida
Wilson T. Sowder
and William D. Rogers

Neonatal Mortality in Florida
Robert M. Thorner, M.B.A., and
Everett H. Williams Jr., M.S. in Hyg.

Tuberculosis in Florida State Prison Hospital
Mark E. Adams and Clarence M. Sharp

MEDICAL DISTRICT MEETINGS, OCTOBER 30 - NOVEMBER 2

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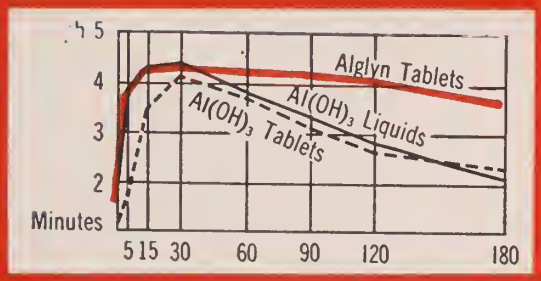

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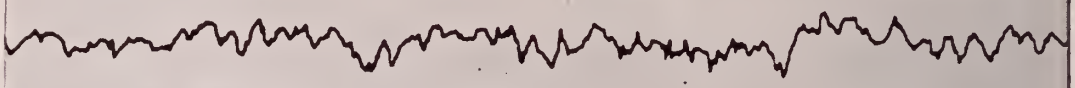

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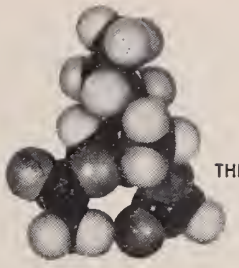

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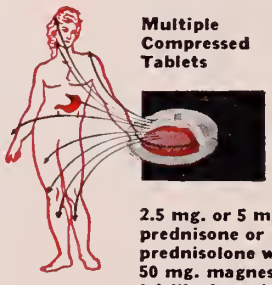

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Surgical Aspects of the Common Bile Duct

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AND
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The discussion of any operative procedure properly should begin with consideration of the indications for its use. There are those who advocate routine exploration of the common duct at the time of cholecystectomy based upon the finding of varying percentages of asymptomatic stones. It is true that in the best hands the morbidity rate of choledochostomy is low, but it must be realized that the procedure is not entirely without hazard. A variety of complications has been reported. We believe it to be sounder policy to explore the duct in selected cases, and the decision in every instance should be made upon the basis of clinical judgment and the findings at operation. Most of the indications are well established and will be accorded only passing mention. Some aspects warrant greater attention.

PREOPERATIVE INDICATIONS
Posthepatic Jaundice—Current
Posthepatic Jaundice—Past
Recurrent Jaundice with Chills and Fever
Frequent Severe Attacks of Colic

Jaundice

Currently existing jaundice is the most obvious reason to consider exploration of the common duct. It is important to differentiate, if possible, between jaundice due to posthepatic ductal obstruction and that resulting from other causes.

Thorough investigation of the patient is essential, but in this era of constant effort to find more exact methods of diagnosis, surgeons may be inclined to rely too heavily upon laboratory and x-ray procedures and to ignore some of the more fundamental observations immediately available to us. We must employ laboratory and x-ray methods, but should use them intelligently and not as a substitute for clinical observations. The most important factor in resolving a difficult differential diagnosis may well be a careful history.

It is seldom difficult to exclude prehepatic jaundice by clinical and laboratory means. A history of protracted jaundice of mild degree, with or without periodic variations of intensity, and associated with normal urine and stools in a patient not otherwise ill, is almost diagnostic of prehepatic jaundice. Enlargement of the spleen, spherocytosis, reticulocytosis, increased fragility of the erythrocytes and increase in stool and urine urobilinogen complete the diagnosis.

Prehepatic jaundice is dependent upon excessive blood destruction. In certain acute infections blood destruction may reach a level productive of jaundice, but the cause is usually apparent.

PREHEPATIC JAUNDICE	
Stool—Normal to Dark	
Urine—Bilirubin Absent	
Urobilinogen Increased	
Van Den Bergh—Direct - Negative	
Indirect - Positive	
Blood—Spherocytes - Reticulocytes	
Increased Fragility	
Spleen—Enlarged	

When the erythrocytes disintegrate at a normal rate, the pigment-containing portion, bilirubin proteinate, is carried to the liver where it is converted into bilirubin and secreted in the bile. Bilirubin in turn is converted into urobilinogen by the action of intestinal bacteria. The major portion is absorbed and returned to the liver, where most of it is again converted into bilirubin.

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Some gains the general circulation and is excreted by the kidney.

In instances of excessive blood destruction the pigmentation of the tissues results from the deposition of bilirubin proteinate. The size of the molecule prevents its excretion by the kidney. The urine, therefore, is acholic.

Excessive amounts of bilirubin are passed into the intestinal tract. Consequently abnormally large amounts of urobilinogen are produced and are returned to the liver and are excreted in the stool. The liver is unable to reconvert all of that part returning to it, and increased quantities pass into the general circulation, resulting in increased urobilinogen excretion in the urine.

The jaundice of hepatic origin may be much more difficult to differentiate from that of posthepatic obstruction, especially when the latter is incomplete. In jaundice of hepatic origin the liver cells are damaged. Not all cells are involved at once or to equal degree. Should total involvement take place, death would supervene due to liver failure. Once the disease is established, the number of cells affected is sufficient to impair liver function and to produce jaundice, presumably because of a degree of obstruction resulting from pressure and lymphatic absorption of bilirubin.

HEPATIC JAUNDICE

Stool—Bilirubin Diminished (to Absent)
Urine—Bilirubin - Present
Urobilinogen - Normal (or Increased)
Except in Obstructive Phase
Cephalin Flocculation - 2 plus to 4 plus (Early)
Alkaline Phosphatase - 4 to 12 B.U.
Serum Cholesterol - 150 to 200
Prothrombin Response - Diminished to Absent

Depressed function results in diminished output of bilirubin, and the stools are light. In the intrahepatic obstructive phase no bilirubin reaches the intestinal tract. The reduced flow of bilirubin reduces the amount of urobilinogen produced, but the damaged liver cells lack the normal capacity to reconvert it into bilirubin, and increased amounts may reach the general circulation. Except in the intrahepatic obstructive phase, therefore, when no bilirubin reaches the intestine and no urobilinogen is formed, the urine urobilinogen may be normal or somewhat increased, while that in the stools is diminished.

When obstructive jaundice is complete, no bilirubin reaches the intestinal tract, no urobilinogen is formed, and none is found in the stool or urine. Incomplete or intermittent obstruction results in a confusing variation of findings. Single tests may have little value, but if they are repeated at frequent intervals, a pattern may be established.

Liver function is impaired early in jaundice of hepatic origin. This change may be shown by increased cephalin flocculation and thymol turbidity. The absence of a prothrombin response to vitamin K and disturbance of the albumin-globulin ratio are additional evidence of hepatitis.

The liver cells resist posthepatic obstruction protractedly. Cephalin flocculation and thymol turbidity remain relatively normal for periods of four to six weeks or even longer. The prothrombin response is preserved. The alkaline phosphatase and cholesterol values of the blood are elevated.

POSTHEPATIC JAUNDICE

Complete
Stool—Bilirubin Absent
Urine—Bilirubin Present
Urobilinogen Absent
Serum Cholesterol - 300 plus
Alkaline Phosphatase - 12 B.U. plus
Prothrombin Response - Present
Variations—Intermittent or Incomplete

The results of the various tests can be fairly definite, or confusing and inconclusive. Clinical judgment may be much more reliable. The history, physical findings and progress of the disease are important. Time often will clarify the cause of jaundice, and fortunately there is seldom cause for haste. In obstructive jaundice little is lost by a reasonable delay, and harm may result from unnecessary and ill-advised surgical intervention in hepatic jaundice.

Liver biopsy with a Silverman needle has a place in establishing a diagnosis, but its use is not without hazard. When jaundice has been unremitting for a protracted period, exploratory laparotomy, after adequate preparation of the patient, is indicated. In addition to assisting in establishing a diagnosis, it provides therapeutic opportunities. Drainage of the common duct appears to be beneficial in some cases in which hepatitis is present, jaundice is persistent, and no obstruction can be found.

In evaluating the history of past jaundice, one must take the increased incidence of virus hepatitis into account. It is probable that most sin-

gle instances of transient jaundice in the past without other significant symptoms are due to this cause.

Prior repeated episodes of jaundice following attacks of pain are almost diagnostic of obstruction due to stone. The time element is of importance. If the symptoms have extended over a number of years, malignant disease can almost be excluded.

If the time interval is short, definite conclusions must be reached with care. Contrary to general impression, pain is a frequent symptom of malignant disease. It tends to be more constant and less severe than that produced by stones, but may be of such intensity as to resemble biliary colic or even pancreatitis. Rarely one sees obstruction due to stone in which pain is insignificant or absent.

When once established, the jaundice of malignant disease usually is progressive and complete, but this is not consistently the case. Inflammation superimposed upon a malignant lesion which is still only partially obstructing a duct may produce temporary complete obstruction. This may be relieved as the inflammatory reaction subsides. Sloughing of a carcinoma of the ampulla may relieve obstruction and sometimes is associated with gross intestinal hemorrhage.

The jaundice due to strictures is even more variable. The same is true of that caused by cholangitis, which is often associated with partial obstruction. Most strictures result from previous cholecystectomy and most are traumatic in origin. Some occur as a result of collections of bile about the ducts, inducing fibrosis and constricting them. The incidence of this cause is variously estimated from 5 per cent to 30 per cent. A few strictures occur in patients who have not been subjected to operation. These arise from adjacent inflammation of the gallbladder, erosion by stones, or the possible leakage of small amounts of bile.

Frequently the exact cause of jaundice must remain in doubt until revealed at the time of operation. The important differentiation to be made is that of hepatic from posthepatic jaundice. The latter requires surgical intervention which in most instances should be avoided in the former. A minor item of clinical observation is that while pruritis may be a symptom of jaundice, it seems to be more frequent and more intense in obstructive than in hepatic jaundice.

Biliary Colic

It is assumed that the more frequent and more severe the attacks of biliary colic, especially with posterior radiation of pain, the more likely small, nonobstructing stones are to be found in the duct system. In such instances, the duct should be opened with minimal additional indications.

Operative Findings

Operative findings often dictate exploration of the duct when the history and physical findings have not indicated it in advance. The initial step in operations upon the biliary tract is careful inspection and palpation of the gallbladder, the duct system, the pancreas, and the duodenum. Palpable stones or tumors in the ducts, and a dilated, thickened, inflamed or constricted common duct make exploration mandatory. When stones in the gallbladder are small and the cystic duct is relatively wide, there is strong likelihood of stones in the common duct, and the presence of turbid common duct bile containing cholesterol particles indicates involvement of the duct system. A palpable mass in the head of the pancreas or at the site of the ampulla always warrants careful investigation of the duct but seldom the routine type of exploration.

OPERATIVE INDICATIONS

Palpable Duct Stones or Tumor
Tumor Ampulla or Head of Pancreas
Dilated Common Duct
Thickened or Inflamed Common Duct
Stricture of Common Duct

Small Gallstones—Large Cystic Duct
Turbid Bile - Cholesterol Particles
Positive Operative Cholangiogram

Cholangiograms

Intravenous cholografin studies do not provide the striking x-ray contrast one would desire, but usually are sufficiently definite to warrant interpretation of the films. Filling defects suggestive of stone, obstruction at the ampulla and even strictures may be demonstrated. Recent studies indicate that duct size is of importance. When the diameter of the common duct is greater than 1.5 cm., stones or other causes of obstruction are found in a high percentage of cases. It should be borne in mind that layering of the dye in the gallbladder may resemble the appearance of multiple small stones in ordinary cholecystograms.

Operative cholangiograms have enjoyed varying popularity. We use them occasionally, usually in cases of doubt. If there are other indications for exploration, they add little, are time-consuming and occasionally misleading.

Postcholecystectomy Symptoms

Following removal of the gallbladder, persistence of symptoms or their recurrence in the form of pain or jaundice necessitates investigation and frequently operation. The symptoms may be due to overlooked stones, strictures, sphincter fibrosis or biliary dyskinesia. Digestive symptoms without pain probably will subside spontaneously or with medical treatment and alone do not constitute an indication for reoperation.

POSTCHOLECYSTECTOMY INDICATIONS

- Posthepatic Jaundice
- Persistent or Recurrent Symptoms
- Intravenous Cholangiograms
  - Demonstrable Stone
  - Demonstrable Stricture
  - Duct Diameter Greater Than 1.5 cm.

Pancreatitis

Exploration of the duct is indicated in operations for pancreatitis. Removal of stones and protracted drainage with or without sphincterotomy may be beneficial. Additional procedures may be required, particularly in the chronic, relapsing and calculous forms.

Related to Other Procedures

Identification of the position of the duct with relation to low-lying duodenal ulcers and duodenal diverticula may avoid surgical catastrophies. This can be done by opening and passing a probe through the duct. This method facilitates dissection and adds greatly to its safety.

Technics of Exploration

The exact procedure of exploration of the biliary tract necessarily depends upon the pathologic changes found at operation. In patients being subjected to operation for the first time, it can be fairly well planned in advance, but must be subject to alteration according to the findings.

INCISION. — The type of incision is influenced by the flare of the costal margin, the placement of previous incisions and the natural preference of the surgeon. Adequate exposure is essential. We believe a long right paramedian muscle-retracting incision, which places one immediately over the duct area, can be enlarged easily and facilitates manual intra-abdominal retraction, to be generally most satisfactory.

ABDOMINAL EXPLORATION. — Palpation and inspection of the stomach, duodenum, pancreas, liver, gallbladder, and duct system may determine the need for exploration of the duct, the method of doing so, and whether the gallbladder should be initially removed or preserved.

The information gained by external examination of the common duct is limited, but palpation of the supraduodenal portion of the duct with a finger through the foramen of Winslow may identify stones or tumors. The retroduodenal portion is more difficult to palpate. Masses in the head of the pancreas or duodenum may be identified.

The size of the duct can be measured by placing the head of a Bakes dilator beside it. The normal duct is not commonly more than 1 cm. in diameter. Thickening of the duct wall by fibrosis or inflammation can be estimated.

CHOLECYSTECTOMY. — If the duct is to be explored, a decision must be reached concerning prior removal of the gallbladder. If the problem be that of stone or inflammation, cholecystectomy will be performed, and if done before the duct is explored, the anatomy will be clarified and the procedure facilitated.

If the problem appears to be one of a malignant growth or firm, obstructing induration in the head of the pancreas, the gallbladder should be preserved until the definitive procedure has been selected. It may be of great value in re-establishing the flow of bile into the intestinal tract.

IDENTIFICATION OF THE DUCT. — Anomalies are frequent, but the common duct normally lies anterior to the portal vein and to the right and anterior to the hepatic artery. Its identity usually can be readily established, particularly after dissection of the cystic duct. Anatomic variations and inflammation may make recognition difficult. Aspiration with a small needle can complete the identification. No harm is done if the portal vein is penetrated, and serious injury to that structure may be prevented.

The character of the bile supplies additional information. Turbid bile makes duct exploration mandatory. Operative cholangiograms may be made by introduction of the solution at the time.

OPERATIVE CHOLANGIOGRAMS. — There is wide difference of opinion concerning the value of cholangiograms taken prior to opening of the duct. In our experience, they have limited ap-

plication, are sometimes misleading and delay the operation. The delay can be minimized if they are taken immediately prior to cholecystectomy. Occasionally, they supply valuable information and are principally useful in cases of doubt.

Supraduodenal Exploration. — With due allowance for anatomic variations, the incision is placed a short distance below the entrance of the cystic duct. The length of incision will vary somewhat, but a fairly good rule of thumb is that it should be about as long as the diameter of the common duct.

Guy sutures of fine cotton or silk are placed immediately after a small opening has been made in the duct. These stabilize the duct and control the opening with minimal trauma.

The escaping bile is observed for stones, liver sand and turbidity. The incision is enlarged to the desired size, and scoops are passed first downward and then upward to remove stones, sand or mud. The scoop should hug the back wall of the duct in an effort to get beyond stones rather than pushing them ahead. The grating of hard stones may be felt. The exploration is repeated with curved stone forceps.

A catheter is then passed into the hepatic ducts, and they are gently irrigated with salt solution or water. The duct opening is watched for small stones or debris which may be washed out of the ducts. The irrigation is then repeated downward.

A blunt, malleable probe which can be bent to conform to the course of the duct is passed downward in an effort to reach the duodenum. If the duct is clean and there is no fibrosis of the sphincter of Oddi, it can be passed into the duodenum with minimal resistance.

No great force should be used as it is possible to perforate the duct with even a fairly blunt probe. The probe can be felt in the duodenum, and the metal color can be seen through a tented-up single thickness of thin duodenal wall, but not if the end of the probe is lodged in the ampulla.

There is difference of opinion concerning the value of dilating the ampulla. We believe that it has value and routinely pass graduated Bakes dilators in the belief that small stones not discovered at the time subsequently may pass through the dilated sphincter. It is always possible to overlook stones, and the smaller they are the more easily they are overlooked.

Retroduodenal Exploration. — If it be suspected that a stone is impacted or lodged in a pocket adjacent to the retroduodenal portion of the duct or induration is felt along its course, this part of the duct should be exposed. The peritoneum is incised lateral to the second portion of the duodenum, which is then reflected medially, exposing the duct. An impacted stone can be removed by incision in the duct wall directly over it. After the patency of the duct has been demonstrated, this secondary incision can be closed.

Some surgeons advise an effort to displace a stone upward, or to crush it and remove the fragments through the supraduodenal incision. We believe this to be less accurate and more traumatic than the direct approach unless the stone is easily displaced or is soft and friable.

With a probe passed through the supraduodenal incision to the duodenum, the retroduodenal portion of the duct can be well palpated practically to the ampulla. This examination can be most easily accomplished if the surgeon stands on the left side of the patient and manipulates the probe with the right hand while palpating with the fingers of the left.

Transduodenal Exploration. — If a stone lodged in the ampulla cannot be easily displaced upward and removed or if a probe cannot be passed into the duodenum, transduodenal exploration is indicated. The lower portion of the descending limb of the duodenum is incised longitudinally. The ampulla is situated at a point inferior to that shown in most texts and should be sought at a corresponding level.

When a stone is present, the ampulla ordinarily can be recognized fairly easily. A probe in the duct pressing against the stone stabilizes the part, and an incision is made directly over the stone, which is removed with forceps. We believe this procedure to be preferable to forceful efforts to dislodge the stone or to fragment it and attempt to remove it from above.

Bleeding is controlled, and the duodenum is closed transversely with two layers of sutures. The closure should be performed with care, and covering the incision with a tag of omentum will minimize the danger of duodenal fistula.

Fibrosis of the Sphincter of Oddi. — When a probe cannot be passed into the duodenum and no stone or tumor is present, it must be assumed that fibrosis of the sphincter of Oddi has taken place although certain other abnormalities such as acute angulation of the terminal portion of the duct may exist.

The duodenum is opened in the same manner. The constricted ampulla may be difficult to rec-

ognize. A catheter with the end cut transversely is passed down the duct to the sphincter and water and air injected. The fluid and bubbles emerging will identify the tiny opening, and a fine probe can be inserted. This is followed by a grooved director, and the fibrotic sphincter is divided by incision over the director. The incision should be no more extensive than necessary to achieve its purpose.

Instruments have been devised to accomplish division of the sphincter from within the duct after passing them through the supraduodenal opening, but are mentioned only to be condemned. There is no substitute for direct vision. If one is to avoid trouble and control bleeding which may occur, complete exposure is essential.

Drainage of the Common Duct. — Some variety of external drainage of the common duct must be employed. In simple cases a fenestrated catheter secured by a catgut suture will suffice, but possesses no real advantage over the "T" tube. The size and length of the tube will be determined by existing circumstances.

The horizontal limb is deeply notched opposite the vertical limb and the ends beveled. This facilitates insertion of the tube and is particularly important in minimizing the trauma of its subsequent removal. If used following routine exploration, the horizontal limbs are short. If the sphincter has been incised, the descending arm is passed into the duodenum and must be longer. The tube ordinarily should be smaller than the inner diameter of the duct to permit the flow of bile about it. A tube may become plugged with mucous or pigment deposits. If it is too snug, obstruction may develop. A tube which fits too tightly at the ampulla may obstruct the pancreatic duct.

The duct is closed tightly about the tube with interrupted fine catgut sutures. The vertical limb and a Penrose drain, the inner end of which lies in Morison's pouch, are brought out through a stab wound away from the main incision. This procedure reduces the hazard of wound complications. Both are secured by sutures at the skin margin.

Postoperative Cholangiograms.—After the duct has been sutured about the tube, cholangiograms may be made prior to closure of the abdomen. In all cases, x-ray studies are made prior to removal of the tube. Aqueous iodine solutions usually provide adequate information, but occasionally inconclusive shadows suggestive of residual stones are seen. Unders these circumstances, it is wise to repeat the study with thin lipiodol.

In routine cases, after an experimental period of clamping the tube and no abnormality has been demonstrated by cholangiogram, the tube may be removed. Removal is customary prior to discharge from the hospital.

Residual Stones. — Most common duct stones present after exploration of the duct were overlooked at the time of operation. Any surgeon who explores enough common ducts will have this experience. Careful, systematic exploration will minimize the number of stones left behind. Small stones, which are most apt to be overlooked, usually will pass through the dilated sphincter.

An effort may be made to dissolve or reduce the size of stones by instillation of ether or chloroform, or to flush them out by the method of Best. The introduction of solvents may produce rather pronounced reaction. Our experience has been that sizable stones usually require operative removal.

We have seen a few cases in which stones have formed in the duct system. In these, the ducts contained so many stones that they could not have been overlooked at operation.

Strictures and Defects. — As mentioned earlier, most strictures are the result of operative trauma in the course of cholecystectomy. Some arise from fibrosis induced by postoperative bile collections, and only a rare instance of stricture occurs in patients who have not been subjected to operation. Avoidance of strictures is far superior to an effort to correct them after they occur. Except for those of congenital origin, all duct defects result from surgical trauma.

Adequate exposure, careful demonstration of the anatomy, awareness of anomalies, control of bleeding, gentle dissection and free drainage will prevent most of them. Many injuries to the ducts occur as a result of blindly clamping in a pool of blood in an effort to control hemorrhage. The cystic artery should be secured and ligated early. If it is divided accidentally prior to clamping or if it retracts from a clamp before ligation, bleeding can be controlled by compressing the hepatic artery between the thumb and finger in the free margin of the foramen of Winslow. Blood can be aspirated and the field left clean. By releasing the pressure for short periods, the bleeding point can be found and secured without injury to other structures.

Carelessness in dissection is another cause of duct injury. The junction of the cystic and hepatic ducts must be clearly demonstrated. If the anatomy is obscure, removal of the gallbladder from the fundus down is much safer than retrograde cholecystectomy.

Some patients have extremely mobile duct systems. These can be tented up by traction and should be permitted to fall back into normal position prior to clamping or ligating the cystic duct. Failure to do so accounts for a large part of the duct injuries occurring in instances of "unusually easy cholecystectomy."

Haste in dealing with the ducts and blood vessels is never justified. This is in reality "the half inch in which a patient may be ruined for life."

Once established, strictures or defects in the ducts present a real challenge, and their correction may be one of the most difficult of abdominal surgical procedures. They require measures to re-establish the free flow of bile into the intestinal tract.

Mucosa to mucosa anastomosis is essential to success. Efforts to bridge gaps with prostheses are destined to failure in the long run unless we can develop materials superior to those which have been used to date. Temporary good results may be obtained, but most of the prostheses plug and if they are dislodged prior to complete healing, or if too much scar tissue is laid down, stricture again develops.

If a stricture is short, the best method of dealing with it is by resection and end to end anastomosis of the duct. One limb of a "T" tube must pass beyond the site of anastomosis. The tube must be introduced through a separate incision in the duct, and the vertical limb must not be brought out at the point of anastomosis. The proximal duct tends to be dilated and the distal contracted. The latter may be gently dilated. The tube should be as large as the distal duct will accept without trauma or too great pressure.

A single row of fine chromic catgut interrupted sutures is used to approximate the duct ends about the tube. A few additional sutures are placed to prevent tension upon the anastomosis.

The same method is used in repair of defects if possible. If these are small and repair is undertaken early, there is reasonable chance of success. Interference with the blood supply of the duct should be avoided if possible in the course of mobilization. Inadequate blood supply may account for some failures.

In the event the ends of the duct cannot be brought together or the distal duct cannot be found, as is frequently the case in large defects and after repeated operations, indirect methods of restoring bile flow must be used. These lack the protective sphincter mechanism and are frequently followed by ascending infection.

This result can be avoided partially by using a Roux "Y" limb of jejunum about 15 inches in length. Choledochogastrostomy and choledochoduodenostomy are almost always followed by ascending infection. It is common to see the duct system largely outlined by barium after its administration in gastrointestinal studies. This occurrence demonstrates how easily stomach and duodenal contents gain access to the duct system following such anastomoses. The convenience of using the duodenum or stomach in anastomoses is outweighed by the frequency of serious infection. Some reflux may take place through the jejunal limb, and various plications have been designed to prevent this. These appear ineffective and add nothing if the limb of jejunum is sufficiently long. Evidences of infection are seen in postmortem examinations, but symptoms usually are mild or absent during life.

Identification of the duct is extremely difficult when it is embedded in the liver and scar. Dissection of the scarred porta should be undertaken from the lateral aspect and should proceed medially. This approach reduces the hazard of injury to the portal vein and the hepatic artery.

At times, the duct may be located by repeated needle puncture and aspiration. If sufficient duct can be found, the anastomosis is made outside the liver. This must apply mucosa to mucosa. Additional sutures are taken to prevent tension. The union is constructed about a large-sized "T" tube, the vertical limb of which is brought out through a separate opening in the jejunum.

When it is necessary to burrow into liver tissue, a modification of the Hoag procedure is employed. The serosal and muscular coats of the jejunum are removed. The mucosa is trimmed to fit the end of a "T" tube in tapering fashion and sutured to the tube. In this way it is hoped to accomplish mucosa to mucosa application by inserting the cuff into the duct. The jejunum is then sutured in place.

The ingenious Longmire procedure involves

resection of enough of the left lobe of the liver to find a duct of sufficient size to warrant anastomosis with the jejunum. This is an extensive undertaking and should be reserved for cases in which other procedures have failed.

Many varieties of prostheses have been used in construction of anastomoses between the biliary and gastrointestinal tracts. We prefer the latex "T" tube because it will remain where it is placed and the time it will remain can be controlled. The tubes are left in place for at least three months and on occasion for as long as three years. Removal of the tube frequently is followed by a transient febrile reaction which may be accompanied by jaundice of mild degree. The reaction usually subsides quickly under antibiotic therapy.

If mucosa to mucosa approximation can be made without tension, the results are satisfactory as a rule, and 70 to 75 per cent good results are reported in extensive series. If not, they are disappointing.

Carcinoma

Carcinoma of the pancreas remains an unsolved problem. The Whipple procedure and its various modifications have demonstrated the feasibility of pancreaticoduodenectomy and that they are compatible with satisfactory physiologic status. Occasional good results are obtained, but in most instances the carcinoma is too far advanced to permit total removal. The mortality rate is high. This procedure should be reserved for the occasional early case and for carcinoma of the ampulla of Vater, in which the results are better. If the lesion is extensive or metastases are present, a cholecystojejunostomy with a Roux "Y" loop is a wiser procedure.

Carcinoma of the duct system has an extremely bad prognosis regardless of the method of treatment except when the lesion is in the distal extremity of the duct and lends itself to wide excision by means of pancreaticoduodenectomy. Otherwise, even the relief of jaundice is seldom protracted.

Summary

The indications for exploration of the common bile duct are discussed.

Routine exploration at the time of cholecystectomy is not advised.

The differential diagnosis of prehepatic, hepatic and posthepatic jaundice is outlined.

The technics of exploration are described.

The etiology and treatment of strictures of the duct are discussed.

Carcinoma of the head of the pancreas remains an unsolved problem. Pancreaticoduodenectomy should be reserved for early cases, carcinoma of the distal extremity of the duct and that of the ampulla of Vater.

490 Post Street.

Medical District Meetings

Dr. Herschel G. Cole, of Tampa, chairman of the Council of the Florida Medical Association, has announced that the 1957 Medical District Meetings will be held from October 30 to November 2. The meeting in District A is scheduled for Tallahassee, October 30; in District B at Ocala, October 31; in District C at Tampa, November 1, and in District D at West Palm Beach, November 2.

Future of Mental Health in Florida

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It is generally accepted, at the present time, that mental illness is one of the major health problems facing the medical profession and the nation. Although it is not the leading cause of death, it is the leading cause of illness, and it certainly outranks all other diseases as a cause of disability, as a cause of hospitalization, and in the cost it imposes not only on the individual sufferer and his family but on the public as a whole. If we look, even briefly, at a few of the facts concerning the magnitude and the cost of mental illness, we can begin to appreciate its real magnitude and urgency.

Mental Illness in the United States

About 9,000,000 people in the United States are suffering from some form of mental illness.

Fifty-four per cent of the total number of hospital beds are devoted to the care of the mentally ill.

During the past 10 years the population in the United States has increased 20 per cent, but the population of mental hospitals has increased 44 per cent.

Of the 750,000 patients in mental hospitals, 96 per cent are in institutions supported by tax funds, at a cost of more than $1,000,000,000 per year.

During the last war, one out of every eight men examined at induction centers was rejected for neuropsychiatric disorders, and the total loss in manpower from mental illness was enough to man 177 army infantry divisions.

It is estimated that $3,500,000,000 is lost in earnings and $418,000,000 is lost in federal income tax each year because of mental illness.

Mental Illness in Florida

In Florida there are approximately 10,000 patients being cared for in mental institutions, including the Farm Colony at Gainesville; over 5,000 cases of juvenile delinquency come before the courts each year, there are approximately 400 suicides, 20,000 divorces each year, and there are an estimated 20,000 chronic alcoholics in the State.

The recent session of the Florida legislature appropriated for the present biennium more than $35,000,000 for the various agencies concerned with mental health programs in the state.

Current Interest in Mental Health

The increasing cost of hospitalization and the actual numerical increase of mentally ill persons and those with emotional and personality disorders, as well as the shortage of well trained personnel to care for them, have forced legislators, professional people and the general public to recognize that something must be done about mental illness. Since the passage of the National Mental Health Act in 1946, the Congress has shown consistently increasing interest in mental illness. This Act created the National Institute of Mental Health within the Public Health Service and made available limited grant-in-aid funds for community mental health programs in the states. The last session of the Congress provided a modest increase in these funds and also a sizable increase in funds for research and training. This Congress also passed a bill which provided for a National Mental Health Survey, plans for which were announced early this year.

The care and treatment of the mentally ill and the prevention of mental illness have been on the agenda of the National Governors Conference for the past several years. The Southern Governors Conference has devoted considerable time to the discussion of mental illness and health during the past three years, and in 1954 requested the Southern Regional Education Board to conduct a survey of mental health facilities for research and training in the Southern states. As a result most of the states involved, including Florida, participate on a permanent basis in the Southern Regional Council on Training and Research in

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Mental Health. Several states, including Florida, have passed bills providing funds for research and for the training of professional mental health personnel.

The interest of the Florida legislature was well indicated during the last session when it passed seven out of eight items of a mental health program sponsored by the Florida Association for Mental Health, and created an Interim Committee to study the mental health problems in Florida and report its findings and recommendations to the next legislature.

Public interest in mental health is reflected in the growth of both professional and lay organizations devoting themselves to educational activities, fund raising, legislative programs, and service programs. Many of these devote their activities to rather specific and limited areas of mental health, such as retarded children and alcoholism, while others, such as the National Association for Mental Health, are concerned with the entire problem. Many leading civic organizations have mental health committees which are active.

Institutions

According to the best records available, the first mental hospital in Florida was established in 1876 and was located near the town of Chattahoochee on the site of an arsenal built by the federal government in 1834. Prior to that time Florida contracted for the care of its mentally ill patients with neighboring states. The buildings in this arsenal were converted into a hospital and have continued to serve the State of Florida since, this being the only mental hospital in Florida until 1947. In that year the state obtained two airfields from the federal government and converted these buildings into the Arcadia branch of the Florida State Hospital. While this served a worth while purpose, relieving considerably the overcrowding at Chattahoochee, we still find conditions badly overcrowded in both institutions in spite of the many buildings that have since been added. For many years, those working directly in this field have recommended and strongly stressed the need for a regional hospital program in Florida, realizing that the hospital at Chattahoochee already far exceeded in patient population the size recommended for this type of institution and also that it was too remote from the heavily populated areas to serve best the needs of the entire state alone.

The regional hospital plan which has been recommended and is gradually being put into effect calls for a mental hospital to be built on the lower East coast, another in the Northeast area, and a third in the Southwest area, and a fourth in the central part of the state. This plan also contemplates that these new hospitals not exceed a patient population of 1,500, which is the generally accepted maximum size for efficient operation and optimum patient care.

We realize it will take many years to accomplish fully this hospital program, but definite progress is being made under a systematic plan. The legislature in 1953 appropriated $5,000,000 for a hospital in Southeast Florida. Located in Broward County, it is now under construction and should be completed by 1957. The 1955 legislature appropriated another $5,000,000 for additional facilities there. Upon completion of this second phase of construction, approximately 1,400 beds will be provided, and all services necessary will be available to operate this complete new mental hospital. The 1955 legislature also appropriated $4,000,000 for a Northwest Florida mental hospital and located it in Baker County. The architects and engineers are now drawing plans for this new institution, and it will be determined later whether funds are available to begin construction within the present biennium.

We are convinced that by locating mental hospital facilities within reasonable distances to all the people of the state we will help solve some of our many problems. It will make possible the proper operation of outpatient clinics and the follow-up and treatment of patients who are on trial visits home, and will provide a day treatment program for many of the patients. These programs are essential in keeping to a minimum the number of patients requiring long term hospitalization and should save the state a great deal of money. It is not only cheaper for the state for the patient to be at home if at all practical and possible, but it is better for the patient.

We cannot stress too strongly, however, the need for supplementary psychiatric beds and outpatient facilities not connected administratively with the state mental hospital system. We believe that all of the larger general hospitals should have beds for the mentally ill, and also outpatient facilities where practical. Our two medical schools must, in order to perform their basic functions of undergraduate and postgraduate training, and research, have inpatient and outpatient services for

psychiatric patients. Also, we must not forget that the practicing psychiatrist in his own office can and is rendering invaluable help in lightening this crushing load that rests on the shoulders of our taxpayers. Furthermore, every practicing physician in the state frequently has to deal with the mentally ill, and can with intelligent and sympathetic handling of such patients contribute immeasurably to this tremendous task.

Community Mental Health Programs

Like other types and classes of diseases, at least some of the mental illnesses and emotional disorders can be prevented. The most definite success in this area to date has been in the prevention of paresis due to syphilis. It is believed, however, that the increasing effort in this field, making the best use of our present knowledge and helped by the products of accelerated research programs, will make a vast contribution to the solution of one of the most pressing problems of our civilization. Representing a substantial part of the community mental health program in Florida are the 14 mental health and child guidance clinics operating in our major population centers.

The State Board of Health meets an estimated 40 per cent of the operating costs of these clinics through state principally but with some federal appropriations. They receive additional support from local school boards, county commissioners, community chests and other official and voluntary agencies. These clinics see thousands of children and their parents each year, and provide diagnostic, evaluative, counseling and limited treatment services — as well as offering consultation, mental health education, and research services to the community.

To provide the optimum in community services these clinics should be built around a team composed of one or more psychiatrists, psychologists and psychiatric social workers. This is the ideal complement, but it is not always possible because of the lack of trained personnel available. Since the establishment of the first clinic in 1944 to the present time there has been an acute shortage of personnel. At this moment we are searching for psychiatrists, clinical psychologists and psychiatric social workers to fill budgeted positions which are vacant. Since these clinics are located in only 15 counties, there remain 52 counties which do not have clinics. While it is true that all clinics are willing to give a limited service to residents of surrounding counties, they are actually able to meet only a small part of the needs of such counties for mental health services. In addition, these outlying counties have fewer resources, such as family service agencies, child welfare units, and visiting nurse associations, not to mention the lack of specialized personnel such as psychiatrists, clinical psychologists, physicians and counselors.

Some form of preventive mental health service is needed in these areas that are unable to support a clinic staff. Consequently, a plan has been developed for extending mental health services to the smaller counties and for strengthening the existing program in the larger counties. This plan provides for the assignment to the county health department staffs of persons who are trained in mental health technics and practices. These workers are to serve as sources of information on mental health services and facilities and to assist in the referral of persons in need of these services. They will carry on a program of mental health education, working closely with parents, teachers, physicians, nurses and the courts, and provide help for those in need of such services. Other functions of these workers are to assist in providing mental institutions with information concerning patients committed, to assist in the supervision of furloughed and released patients, and to work with the families of the patients who are in mental institutions. This program was authorized on a limited basis by the last session of the legislature. Several of these workers are now on duty. This demonstration project appears to be quite successful and seems to be a practical method of providing some services to the smaller counties. The response of the communities served has been most enthusiastic, and we have received more requests for this service than can be provided.

Research — Training

Research in mental illness is and has been scarce in spite of the magnitude of the problem, the tremendous financial burden it places on people and our relative ignorance of the causes, means of prevention and treatment. Research in mental illness is not getting the support it needs. Funds available annually for research on mental illness in the United States amount to only about $4.15 per patient under treatment, as compared with $28.20 for polio, $26.80 for tuberculosis, and $27.70 for cancer.

The 1955 Florida legislature set aside $18,000 for the 1955-1957 biennium for research in this

area. Upon the recommendation of the Council on Training and Research, the State Board of Health has made two small grants to assist worthy research projects at the University of Miami School of Medicine.

The question arises as to where we will obtain trained personnel to staff the new hospital facilities, clinics and other facilities. We all realize that there is a shortage not only of psychiatrists but also of psychiatric social workers, clinical psychologists, psychiatric nurses and other ancillary personnel. Of the 80 or 90 psychiatrists in private practice in Florida, approximately half are located within the vicinity of Miami. One fourth of the psychiatrists in Florida are located in the Tampa–St. Petersburg area, and the remaning 20 to 25 are located in the 14 next most populous counties. There are approximately 35 to 40 qualified clinical psychologists in Florida, less than 35 psychiatric social workers, and still fewer psychiatric nurses.

The 1955 legislature, recognizing this shortage, took steps to provide scholarships for the training of personnel in these professions, to be awarded by the State Board of Health upon the advice of the Council on Training and Research. To date scholarships have been awarded as follows: Three have been granted for psychiatric residents and nine for psychiatric social workers; applications are being accepted for psychologists and psychiatric nurses. It would be unfair not to mention the fact that this shortage is found not only in Florida but in most other states as well. This shortage has been increased because all the states, as well as the federal government, have been rapidly expanding their mental health programs and also because we have failed to encourage young people to enter these particular fields and have not previously provided adequate training facilities.

It is essential that we be able to look to the two medical schools in Florida for leadership in the training of an adequate supply of well trained psychiatrists for the needs of the state. The medical schools will also, we are sure, give due attention in the training of general practitioners and specialists in other fields to the protean manifestations of mental and emotional disturbances in all phases of the practice of medicine. While medical schools are not usually responsible for the undergraduate training of clinical psychologists and psychiatric social workers, we believe that they and their affiliated hospitals and clinics can offer the best facilities for postgraduate training and experience in these fields. We believe that our medical schools must weld our young psychiatrists, clinical psychologists, psychiatric social workers, and psychiatric nurses into an effective team. We need more trained personnel in all these professions, and we need trained workers who have already learned how each of the several professions can best work with the others. We think that it is natural for our medical schools to take the leadership in such training.

We are happy to see that the University of Miami School of Medicine is already making great progress in this direction, and we believe that the plans for such training at the College of Medicine of the University of Florida are among the best in the country. We are distressed, however, to learn that because construction costs were greater than was estimated, the entire floor that was planned for psychiatric patients is not to be built. Without proper facilities for the outpatient care and inpatient treatment of mental illnesses our state medical school cannot offer postgraduate training to physicians in psychiatry or to the allied professions; nor for that matter can good undergraduate training be given. It is understood that considerable difficulty may be encountered in securing a professor of psychiatry under these conditions. The Governor's Committee on Mental Health in a report made in 1954 strongly urged that the new medical school at Gainesville emphasize the training of psychiatrists and other personnel in the mental health field. This has always been an obligation of all medical schools, and the need was never more urgent than it is today. For one of our two medical schools to be deficient in this respect will leave a gaping hole in the entire plan to care more adequately for our mentally sick in Florida. We know that Dean George T. Harrell Jr. of the College of Medicine of the University of Florida is most acutely aware of this problem, but the provision of funds for a teaching unit for psychiatry there can only be made by the legislature. We hope that the members of the medical profession throughout Florida will give their earnest support to the solution of this problem.

Other Needs

There is need for more widespread factual information and education of the general public in the field of mental health in Florida, as indeed there is throughout the nation. We are integrat-

ing our program of public education in the field of mental health with the general health education programs of the State Board of Health and the county health departments. We are using all the ways available, such as films, television, pamphlets, press releases, radio and speakers, to put before the public reliable information. By the use of symposiums, panels and workshops, and by working through the people most closely involved in problems of human relationships, we are trying to improve the public's knowledge of this important phase of mental health.

The State Board of Health in cooperation with the Division of Postgraduate Education of the College of Medicine of the University of Florida and the Florida Medical Association has supported and sponsored the presentation of postgraduate courses and seminars for the medical profession on such subjects as epilepsy, psychiatry and mental health in general, as well as numerous other subjects related to the practice of medicine and surgery.

Liaison

The State Board of Health and the county health departments have always followed the policy of maintaining a close working relationship and liaison with the medical profession, state and local welfare agencies, schools, law enforcement agencies and civic groups.

Of particular importance is the close working relationship between the State Board of Health and the State Department of Education. For years we have had a close and cooperative working relationship at both the state and local levels in such activities as health education, physical education, the school health program, and the exceptional child program. More recently a new course in "Human Growth and Development" has been added to the curriculum of the elementary and secondary schools.

We are convinced that much can be done in the schools in the prevention of mental and emotional disorders by proper training and instruction. The leaders in the teaching profession are becoming increasingly aware of their responsibilities in this field and are taking intelligent steps to discharge them. More training is being given to teachers in personality development, and in the guidance of children, and the favorable influence of the increasingly enlightened efforts of thousands of our school teachers can be expected to return a harvest of healthier and more stable citizens in the years to come.

Several years ago the state tuberculosis hospitals and the State Board of Health cooperatively developed a plan for coordinating and integrating the hospital treatment with the preventive services. This program has proved invaluable; not only has it been most helpful in the prevention and control of tuberculosis, but it also has resulted in improved care, handling and follow-up of individual cases. Because of a need by the state mental hospitals for similar services, the development of a similar program was begun within the past year. This program makes use of the experience and skills of the public health personnel in areas of prevention, case finding, gathering of case histories and background information, parole and posthospitalization follow-up as well as liaison between the hospital, the patient, the family physician, the patient's family, the courts, and welfare agencies.

One of the greatest problems in implementing mental health programs at the present time is the shortage of trained personnel. The formal training of highly specialized personnel takes many years. Although Florida is beginning to attract more and better trained workers in this field, we can expect the shortage to continue for some time. With the recent advances being made in psychiatry not only in hospital, outpatient and clinic facilities but also in diagnostic methods, treatment and preventive technics, we believe that the future of the mentally ill patient looks brighter; and we are looking forward to the time when the load of inpatients in our institutions becomes less, and the length of the period of hospitalization of these patients will be shorter.

Summary

The large assortment of psychiatric diseases and mental, emotional and social disturbances, commonly called mental illnesses, constitute a problem of tremendous magnitude. They are of vast medical, social, and economic importance.

Florida needs to go ahead in the fulfilment of the plans for regional mental hospitals and outpatient clinics.

We need to enlarge and give more support to our mental health and child guidance clinics. They need more and better trained personnel, and in many cases better clinic facilities.

We need to develop fully the plan for the cooperative working relationship between the mental institutions and the State Board of Health and county health departments.

We should encourage the provision of supplementary facilities for the mentally ill in the general hospitals of the state.

We should encourage the full development of training facilities for physicians and especially psychiatrists in our larger hospitals, and particularly in our medical schools.

Our medical schools should take the leadership in offering faculty and affiliated hospitals and clinics for furthering the postgraduate training of clinical psychologists, psychiatric social workers and psychiatric nurses.

More research in the mental illnesses is needed; and our medical schools should take the leadership in this investigation.

The public is much concerned about mental illness, and the Congress and our own legislature are anxious to help solve the problem. These bodies are getting advice in great quantity from all directions. It is urgent that the medical profession obtain and retain the leadership in making plans for the future in mental health, and that it give wise advice and council to our legislative bodies and to other public and private agencies interested in this subject.

We wish to acknowledge and express our appreciation to R. W. McComas, M.D., W. Laney Whitehurst, M.D., and Paul W. Penningroth, Ph.D., for suggestions and assistance in the preparation of this paper.

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Incidence and Treatment of Pulmonary Tuberculosis in the Hospital of the Florida State Prison

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In the past decade, the therapeutic attack on pulmonary tuberculosis has undergone many changes, some minor, some — in the light of older concepts — almost revolutionary. Greater emphasis is now placed on the chemotherapeutic approach. Such drastic technics as artificial pneumothorax and pneumoperitoneum are used less frequently than heretofore; however, when surgical intervention is employed, it is often more radical.

The most remarkable results have been obtained in the treatment of tuberculosis by the use of antibacterial agents such as streptomycin, paraaminosalicylic acid, and isonicotinic acid hydrazide. On the basis of our experience in the tuberculosis wards of the Florida State Prison Hospital, we feel strongly that all patients with active pulmonary tuberculosis should have treatment with these drugs. This opinion may conflict with earlier theories that drug therapy should be reserved for those patients about to undergo surgery, or those who fail to respond to other methods, but the results obtained in our group of patients have amply justified the antibiotic regimen.

Antibiotic therapy for tuberculosis has been used at the prison hospital only since February 1953. Prior to that time, adequate funds were not available and a standard program of treatment could not be continued without interruption, although such a regimen had been repeatedly urged by the Bureau of Tuberculosis Control of the State Board of Health. Sporadic attempts at treatment with artificial pneumothorax and pneumoperitoneum had been made, but the routines were frequently interrupted for several months at a time by medical staff changes. During the summer of 1952, streptomycin was administered to 20 patients for about two months, but no para-

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Fig. 1. Case 1.—D. G., a woman, aged 23. Roentgenogram taken on Jan. 1, 1953, shows extensive infiltration, the process involving the right upper lobe, with a sharp line of demarcation between the right upper and middle lobes. In the upper lobe, an area of rarefaction indicates a cavity. Diagnosis: moderately advanced tuberculosis, active.

Right upper lobectomy was performed on Dec. 9, 1954; streptomycin and para-aminosalicylic acid therapy was resumed following the operation.

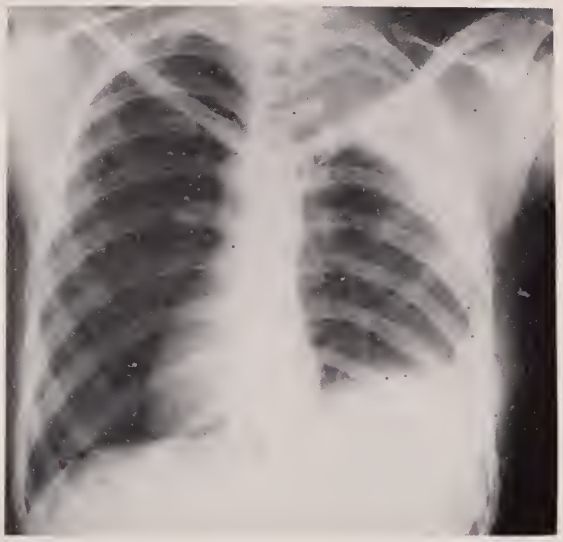

Fig. 2. Case 1.—Postoperative roentgenogram taken on Jan. 4, 1955, shows removal of fourth rib. There appears to be some fluid in the apical portion of the right side of the thorax, but there is no evidence of reactivation of the disease process.

aminosalicylic acid was then available for our use. When funds did become available on Feb. 1, 1953, antibiotic therapy was begun in earnest.

All of the patients in the cases reported here are inmates of the Florida State Prison. In each case, the provisional diagnosis of pulmonary tuberculosis was based on roentgen and laboratory studies made routinely on commitment, and evaluated by the Bureau of Tuberculosis Control, and the State Laboratory. The patients are isolated in a 60 bed annex to the prison hospital, which was built in 1951. This annex consists of four wards; two for patients with active disease, and two for those in whom the disease is considered inactive. Classification is made on the basis of repeated roentgenograms of the chest and laboratory examination of sputum, gastric washings, et cetera.

The number of patients in our tuberculosis wards is increasing steadily. There were 25 being treated in 1945, 41 in 1950, and 63 in 1954. In February 1953, when antibiotic therapy was begun, 28 patients exhibited positive reaction to sputum tests, and were considered to have active pulmonary tuberculosis. During the remaining months of 1953, 7 new patients were admitted, followed by 8 more in 1954. At the present time we have 58 patients with tuberculosis in the prison hospital, in 43 of whom the disease is considered "inactive," with the period of inactivity extending from a few months to several years.

Six months after treatment with antibiotics was begun, only 2 of the original 28 patients continued to show positive reaction to sputum tests. One of these has since been paroled to medical supervision. The other is uncooperative; activity has again been noted after a period of quiescence and negative sputum reports. The remaining 26 have been removed from the "active" list, and although antibiotics have been discontinued in those cases in which the patient is still in prison, the patients remain under observation in the hospital.

Eighteen of our patients are now receiving drug therapy: streptomycin and para-aminosalicylic acid. In 4 cases, the sputum reports are persistently positive; in the remaining 14 these reports are negative, but repeated roentgenograms of the chest show some evidence of active disease processes, and treatment is being continued.

Each of these patients receives 1 Gm. of streptomycin every third day, and 12 Gm. of para-aminosalicylic acid daily. This combination has two distinct advantages: first, the two agents exert an apparent synergistic theraputic effect; and second, the combination seemingly causes a delay in the development of drug resistance. In the few patients responding unfavorably, or exhibiting side effects, we have used isonicotinic acid hydrazide, in conjunction with para-aminosalicylic acid, with excellent results. Generally, however,

Fig. 3. Case 2.—H. J., a man, aged 41. Roentgenogram taken on Dec. 17, 1951, shows an extensive pneumonic type of infiltration involving the entire left lung, with evidence of cavitation. Diagnosis: far advanced tuberculosis, very active.

Fig. 4. Case 2.—Roentgenogram taken March 31, 1953, shows apparently complete clearing of the pneumonic tuberculous process.

we have been able to rely on the intermittent use of streptomycin with daily administration of para-aminosalicylic acid.

In addition to these medications, bed rest is insisted upon. Immediate supervision is not possible because of our limited staff, but in most cases the patients cooperate well. A special diet, different from the usual prison fare, is given each patient. Sputum examinations and roentgenograms of the chest are made at regular intervals, and are evaluated by the Bureau of Tuberculosis Control, whose recommendations are closely followed. The use of artificial pneumothorax and pneumoperitoneum has been discontinued, although surgical procedures are employed when indicated.

The results obtained with this regimen have been uniformly good, and the response observed in a number of cases was particularly gratifying. Figures 1 to 10 are illustrative.

Fig. 5. Case 3.—C. B., a man, aged 45. Roentgenogram taken May 1, 1953, shows extensive infiltrative process involving most of the left lung, with a cavity in the apex. An infiltrative process in the right lung, from the third rib to the apex, will also be noted. Diagnosis: far advanced tuberculosis, very active.

Fig. 6. Case 3.—Roentgenogram taken April 5, 1954, shows a rather phenomenal clearing of the tuberculous process seen in figure 5. There is only scattered evidence of tuberculosis in this roentgenogram.

Comment: A roentgenogram taken Jan. 1, 1955, showed continued clearing, and treatment was discontinued two weeks later.

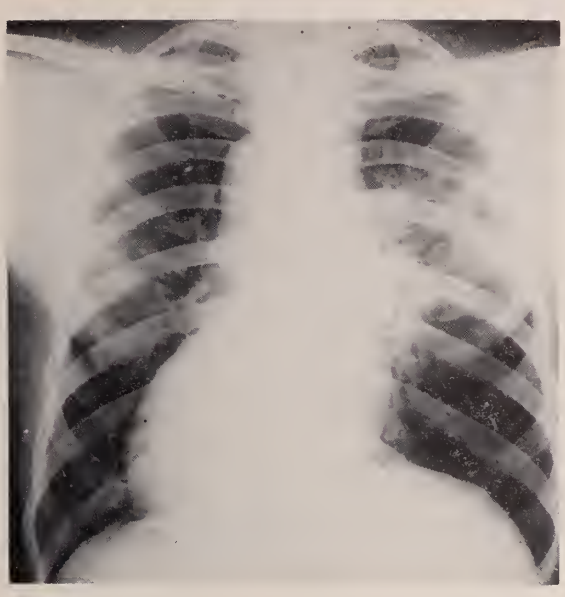

Fig. 7. Case 4.—C. C., a man, aged 54. Roentgenogram taken July 17, 1953, shows an acute infiltrative process involving the right lung field from the fifth rib to the first rib, with an extension to the left lung involving the third and fourth interspaces. Diagnosis: moderately advanced tuberculosis, probably active.

Fig. 8. Case 4.—Roentgenogram taken March 5, 1954, shows definite clearing of the infiltrative process in the upper right lung field. While moderately advanced, the disease is probably now inactive.

Comment: A roentgenogram made Jan. 1, 1955, showed a continued resolution of the tuberculous process. In comparison with the roentgenogram of July 1953 (fig. 7) there had been remarkable clearing. Treatment was discontinued on Jan. 15, 1955.

Discussion

Therapeutic methods must be adjusted to the individual patient, but in pulmonary tuberculosis, long term drug therapy without interruption will produce results which are sometimes startling. There are many such reports in the recent literature, and in most cases a combination of agents was used, such as streptomycin intermittently with daily administration of para-aminosalicylic acid, streptomycin intermittently with daily administration of isonicotinic acid hydrazide, or the administration daily of isonicotinic acid hydrazide and para-aminosalicylic acid. Only a few of our

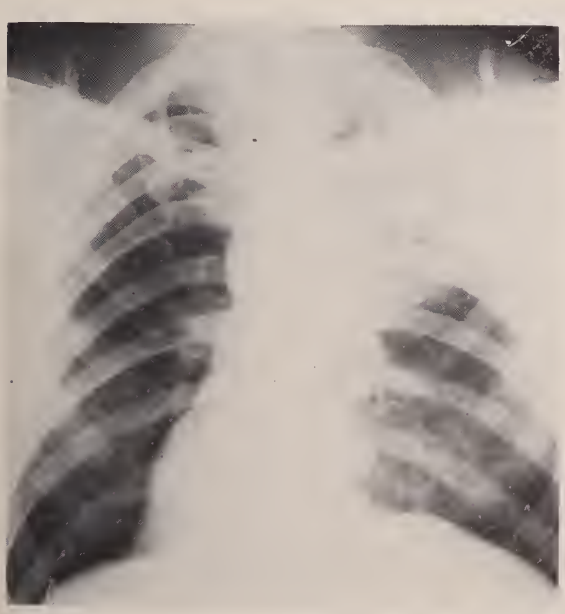

Fig. 9. Case 5.—E. H., a man, aged 36. Roentgenogram taken July 7, 1953, demonstrates an extensive almost pneumonic type of infiltration involving the upper right lung field. Diagnosis: far advanced tuberculosis, active, with cavitation.

Fig. 10. Case 5.—Roentgenogram taken Jan. 4, 1955, indicates that this patient made a remarkable recovery. The extensive disease process that involved almost the entire right lung (fig. 9) has almost completely disappeared.

Comment: Treatment in this case consisted of streptomycin given intermittently and para-aminosalicylic acid administered daily, without interruption, for 16 months. Treatment was discontinued on Jan. 15, 1955.

patients, however, received isonicotinic acid hydrazide, and we are unable to comment on the effectiveness of this drug.

During the two year period covered by this report, there has been but 1 death in our tuberculosis wards. The pulmonary disease in that case was considered inactive; death was the result of a coronary thrombosis.

Despite the excellent responses reported everywhere, much work remains to be done before we can say that streptomycin, para-aminosalicylic acid, and isonicotininc acid hydrazide are definitely curative. They offer hope, but their use must be integrated with a general supportive program, and such surgical measures as are indicated in the individual case.

Summary

Report is made of the increasing incidence of pulmonary tuberculosis in men and women committed to the Florida State Prison; the manner in which these patients are isolated and hospitalized is described.

Therapeutic methods presently used in the treatment of pulmonary tuberculosis in the State Prison Hospital are discussed briefly, as are the results obtained by treatment with such anti-bacterial agents as streptomycin, isonicotinic acid hydrazide, and para-aminosalicylic acid.

The response in representative cases to this therapeutic regimen is described and illustrated.

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Neonatal Mortality in Florida; A Statistical Analysis

Part III: Cause of Death

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In this study, the Sixth Revision of the Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death has been used as a basis for the classification and tabulation of neonatal deaths. This system of statistical classification is based upon the concept of a single underlying cause for each death. The underlying cause is defined as the disease or injury which initiates the train of morbid events leading directly to death. The underlying cause is frequently distinct from the immediate cause of death or mode of dying.

Whenever possible, the underlying cause of death as indicated by the certifying physician on the death certificate is used for statistical classification. Exceptions to this policy are made when the underlying cause is not clearly stated by the certifier and a clarification cannot be secured by inquiry. In these instances, a system of rules is applied to select the most probable underlying cause.

The 1,499 neonatal deaths among single live births in Florida in 1953 were classified to 62 separate detailed causes. Tables 1, 2 and 3 group deaths according to pathogenic categories. From an examination of these tables it is evident that it was necessary to assign many deaths to rubrics of the International List which do not represent the initial point of a pathologic sequence of events. Assignments to nonpathogenic causes such as postnatal asphyxia and atelectasis, prematurity, and ill-defined diseases and causes encompass 59.1 per cent of the deaths in the tabulation.

Atelectasis

Atelectasis is generally viewed as a sequela of another condition rather than an underlying cause of death. According to Potter,[1] "Atelectasis is not to be considered a cause of death. Although non-aeration of the lungs may be the immediate reason for failure to survive, the atelectasis is only a symptom of some underlying abnormality." Over 22 per cent of the deaths included in this study, however, were certified to this rubric.

Table 1.—Neonatal Deaths Among Single Live Births, By Cause and Race, Florida, 1953

Cause of Death	Deaths		
	Total	White	Non-white
All Causes	1,499	959	540
Infective diseases	104	37	67
Pneumonia of the newborn	45	17	28
Diarrhea of the newborn	15	4	11
Tetanus neonatorum	13		13
Meningitis	8	5	3
Umbilical and other sepsis	7	4	3
Congenital syphilis	4		4
All other infective diseases	12	7	5
Congenital malformations	146	110	36
Monstrosity	14	10	4
Nervous system malformations	25	22	3
Circulatory system malformations	51	35	16
Digestive system malformations	22	18	4
Genitourinary system malformations	8	5	3
Other and unspecified malformations	26	20	6
Birth injuries	233	169	64
Intracranial and spinal	112	80	32
Other birth injury	121	89	32
Neonatal disorders arising from maternal toxemia	14	10	4
Erythroblastosis	43	35	8
Hemorrhagic disease of the newborn	19	8	11
Accidents and assault	12	8	4
Asphyxia and atelectasis	334	236	98
Prematurity	471	290	181
Ill-defined diseases, causes and symptoms	81	33	48
All other causes	42	23	19

Prematurity

Prematurity unqualified by additional information accounted for 31.4 per cent of the deaths in this study. Prematurity without complication may or may not have been the underlying cause of the deaths included in this group. Bundesen[2] stated that prematurity alone is not a cause of death. Other workers have attempted to establish criteria for previability among the premature, usually on a weight, size and gestation basis. Diagnostic criteria for previability differ considerably, and there may be some doubt as to the applicability of this term to live-born infants. The group of deaths coded to prematurity therefore represents a large proportion of the neonatal deaths about which definitive causal information is lacking. It is of interest to note that 15 deaths in this category (3.2 per cent) occurred when the weight was over the 2,500 Gm. (5 pounds 8 ounces) used as a criterion for prematurity.

Ill-Defined Diseases

The deaths included in the category of ill-defined diseases, causes and symptoms (5.4 per cent of the deaths) constitute cases for which the certifying physician listed only symptoms or modes of dying.

Much of the failure of physicians to certify more definite causes of death undoubtedly results from the difficulty of making an accurate diagnosis in many instances on the basis of clinical evidence alone. An increase in the number of autopsies and the exercise of greater care by physicians in certifying causes of death would probably yield a great deal of useful information concerning the causes of infant mortality. Even with postmortem examination, however, it is not possible to assign all infant deaths to specific causes. In postmortem studies of 503 premature infants, Potter[1] was unable to find a pathologic cause for

Table 2.—Neonatal Deaths, Per Cent Distribution of Neonatal Deaths, and Rates per 1,000 Single Live Births, By Cause and Race, Florida, 1953

Cause of Death	Deaths			Per Cent Distribution			Rate		
	Total	White	Non-White	Total	White	Non-White	Total	White	Non-White
All Causes	1,499	959	540	100.0	100.0	100.0	19.1	16.8	25.4
Infective diseases	104	37	67	6.9	3.9	12.4	1.3	0.6	3.1
Congenital malformations	146	110	36	9.7	11.5	6.7	1.9	1.9	1.7
Birth injuries	233	169	64	15.6	17.6	11.9	3.0	3.0	3.0
Neonatal disorders arising from maternal toxemia	14	10	4	0.9	1.0	0.8	0.2	0.2	0.2
Erythroblastosis	43	35	8	2.9	3.7	1.5	0.5	0.6	0.4
Hemorrhagic disease of the newborn	19	8	11	1.3	0.8	2.0	0.2	0.1	0.5
Accidents and assault	12	8	4	0.8	0.8	0.7	0.2	0.1	0.2
Asphyxia and atelectasis	334	236	98	22.3	24.6	18.1	4.3	4.1	4.6
Prematurity	471	290	181	31.4	30.2	33.5	6.0	5.1	8.5
Ill-defined diseases, causes and symptoms	81	33	48	5.4	3.5	8.9	1.0	0.6	2.3
All other causes	42	23	19	2.8	2.4	3.5	0.5	0.4	0.9

Table 3.—Distribution of Birthweight by Cause of Death, Neonatal Deaths Among Single Live Births, Florida, 1953

Cause of Death	Deaths by Weight In Grams									
	All Weights	1,000 or Less	1,001-1,500	1,501-2,000	2,001-2,500	2,501-3,000	3,001-3,500	3,501-4,000	4,001-4,500	4,500 or More
All Causes	1,499	334	248	221	200	174	174	99	37	12
Infective diseases	104	3	2	9	17	22	27	15	7	2
Congenital malformations	146		9	16	29	31	33	24	4	
Birth injuries	233	37	28	29	32	43	26	25	11	2
Neonatal disorders arising from maternal toxemia	14	2	2	3	1	1	3	2		
Erythroblastosis	43	1	3	4	6	9	13	4	3	
Hemorrhagic disease of the newborn	19		4		3	2	4	2	4	
Accidents and assault	12	1		2	2	2	5			
Asphyxia and atelectasis	334	63	53	59	54	40	43	16	2	4
Prematurity	471	205	133	82	36	5	6	3	1	
Ill-defined disease, causes and symptoms	81	19	11	13	9	11	9	4	3	2
All other causes	42	3	3	4	11	8	5	4	2	2
	Per Cent Distribution of Weights									
All Causes	100.0	22.3	16.5	14.8	13.3	11.6	11.6	6.6	2.5	0.8
Infective diseases	100.0	2.9	1.9	8.7	16.3	21.2	26.0	14.4	6.7	1.9
Congenital malformations	100.0		6.2	11.0	19.9	21.2	22.6	16.4	2.7	
Birth injuries	100.0	15.9	12.0	12.4	13.7	18.5	11.2	10.7	4.7	0.9
Neonatal disorders arising from maternal toxemia	100.0	14.3	14.3	21.4	7.1	7.1	21.4	14.3		
Erythroblastosis	100.0	2.3	7.0	9.3	14.0	20.9	30.2	9.3	7.0	
Hemorrhagic disease of the newborn	100.0		21.1		15.7	10.5	21.1	10.5	21.1	
Accidents and assault	100.0	8.3		16.7	16.7	16.7	41.6			
Asphyxia and atelectasis	100.0	18.9	15.9	17.7	16.1	11.9	12.9	4.8	0.6	1.2
Prematurity	100.0	43.5	28.2	17.4	7.7	1.1	1.3	0.6	0.2	
Ill-defined diseases, causes and symptoms	100.0	23.5	13.6	16.0	11.1	13.6	11.1	4.9	3.7	2.5
All other causes	100.0	7.1	7.1	9.5	26.2	19.1	11.9	9.5	4.8	4.8
All single live births	100.0	0.5	0.6	1.3	4.8	18.5	37.8	27.1	7.5	1.9

Table 4.—Neonatal Deaths Due to Infective Disease With Rates per 1,000 Single Live Births by Race, Place of Birth and Attendance at Birth, Florida, 1953

Place of Birth and Attendant	Deaths			Rate		
	Total	White	Non-White	Total	White	Non-White
All Infective Disease Deaths	104	37	67	1.3	0.6	3.1
Hospital (physician)	64	35	29	0.9	0.6	2.3
Nonhospital (all attendants)	40	2	38	3.7	1.1	4.2
Physician	8	1	7	3.1	1.1	4.3
Midwife	28		28	3.6		3.9

death in 232 cases (46.1 per cent), and Dunham and McAlenney[3] were unable to classify 14 deaths in autopsy examinations of 38 infants (36.8 per cent).

Infective Diseases

Almost 7 per cent of the deaths in this study were attributed to infections including those of the respiratory tract. The nonwhite rate was over five times the white rate. Deaths from these causes are probably the most readily preventable of the groups listed in table 1.

Predominant among deaths from infective disease was pneumonia of the newborn, which caused 45 of the 104 deaths. Diarrhea of the newborn accounted for 15 deaths, of which 11 were among nonwhites. Two preventable causes of death rarely encountered in many states included in this group are tetanus neonatorum, which caused 13 deaths, and congenital syphilis, which accounted for four. All of these deaths occurred among nonwhites.

Deaths due to infections tabulated according to place of birth and attendance by physician or midwife are presented in table 4.

For each race, hospital mortality rates are approximately half those of nonhospital rates. The difference between the hospital-born and nonhospital-born groups may result in part from differences in social and economic status.

There were more deaths due to infection in the hospital-born group since more births occur in hospitals. No information is available concerning the proportion of infants dying from infective disease during hospital confinement after birth and the number dying subsequent to discharge.

The weight distribution of infants dying from infections was noticeably lower at birth than that of all single live births (table 3). This condition may have predisposed this group to infection.

Congenital Malformations

Approximately 10 per cent of the neonatal mortality in this study was attributable to congenital malformations. The white rate for this cause was 1.9 per 1,000 live single births and the nonwhite rate 1.7. (This difference in rates was not significant statistically at the 5 per cent level).

Malformations of the circulatory system constituted the largest single subdivision of this cause, accounting for 51 of the 146 deaths, or more than one third of the total. Malformations of the nervous system caused 25 deaths and anomalies of the digestive system 22. These figures do not necessarily indicate the relative frequency of these types of congenital abnormality since the data are affected by the ease with which the conditions may be diagnosed clinically.

Birth Injuries

Death rates from birth injuries were identical for both races, 3.0 per 1,000 single live births. About 16 per cent of the mortality in this study was ascribed to this cause. The greater susceptibility of premature infants to birth injuries is indicated by the distribution of weights for this group (table 3). Over half of the deaths due to birth injuries (54.0 per cent) were among premature infants. Slightly less than half of the deaths in this group resulted from intracranial and spinal injuries.

Toxemia

A total of 14 deaths was attributed to disorders arising from maternal toxemia. No figures are available to indicate the number of mothers in this group receiving antepartum care. Thirteen of these births occurred in hospitals and were attended by physicians; one was attended by a midwife.

Erythroblastosis

A total of 43 deaths or 2.9 per cent of the total in this study was attributed to erythroblastosis. Of these, 41 were hospital deliveries. Erythroblastosis is a complicated condition requiring specialized handling by highly trained medical personnel in well equipped hospitals. It might have been possible to prevent some of these deaths if the condition had been detected prior to birth and the patient referred for delivery to a hospital having equipment and personnel necessary for the handling of deliveries of this type.

Hemorrhagic Disease

Of 19 deaths due to hemorrhagic disease, 15 were among hospital-delivered infants and four among those delivered at home. Eight of the deaths were in the nonwhite group. On a rate basis, the incidence is greatest in the nonwhite and nonhospital group. The figures suggest a greater incidence of hemorrhagic disease in infants born to mothers of a low socioeconomic status.

Accidents and Assault

Ten of the deaths included in this study were the result of accidents, and two deaths resulted from assault. Inhalation of food was the cause of five deaths, and inhalation of other substances resulted in three fatalities. One death was attributed to fire and one to mechanical suffocation. Eight of the deaths in this group were among white and four among nonwhite infants.

Summary and Conclusion

A large majority of the deaths included in this study (59.1 per cent) were assigned to causes which gave little or no definite information concerning the pathologic process leading to death. An increase in the number of infant deaths examined by autopsy would probably improve mortality statistics and contribute to a better understanding of factors affecting survival of the newborn. Postmortem studies, however, cannot be expected to provide definite information concerning the underlying cause of death in every case.

The neonatal death rate from infective disease is higher among nonwhites than among whites, and higher among births attended by midwives and by physicians outside of hospitals than among infants delivered in hospitals. Lighter weight at birth is apparently associated with a greater susceptibility to death from infective disease.

About 10 per cent of the deaths in this study were attributed to congenital malformations with anomalies of the circulatory system reported as the most frequently observed fatal congenital malformation. There was no statistically significant difference by race in the death rates for congenital malformation.

Birth injury neonatal death rates are identical for both races, and approximately 16 per cent of the deaths in this study resulted from this cause. Low birthweight appears to be associated with birth injury.

Maternal toxemia gave rise to conditions resulting in the deaths of 14 infants, or 0.9 per cent of the deaths. Some of these deaths may have been preventable with proper antepartum care. No information concerning antepartum care received by these mothers is available.

Erythroblastosis was the cause of 2.9 per cent of the mortality, or 43 deaths, some of which might have been preventable with early detection of the condition and specialized care.

Hemorrhagic disease resulted in 19 deaths, or 0.8 per cent of the deaths.

Accidents accounted for 10 deaths and assault for two of the deaths included in this study.

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Box 210.

ABSTRACTS

Selective Uptake of Zn^{65} by Dorsolateral Prostate of Rat. By S. A. Gunn, Thelma C. Gould, S. S. Ginori, and Jerome G. Morse. Proc. Soc. Exper. Biol. & Med. 88:556-558, 1955.

Noting that up to the present time iodine, which is concentrated in the thyroid gland, has been the only element with sufficiently specific localization in the tissues of an organ to warrant use of its radioactive isotopes as diagnostic and therapeutic tools, these authors present a study using radioisotopes in which they found that another element, zinc, is localized in high concentrations in one gland, the prostate. They describe the procedure and the results, and discuss the striking selectivity of the dorsolateral prostate of the rat to take up Zn^{65} administered by intracardiac puncture. It is their conclusion that the dorsolateral prostate of the rat concentrates Zn^{65} from 15 to 25 times more than any other organ. These concentrations are high enough, in their opinion, to suggest the use of this element in studies of the physiology of the prostate and possibly in the evaluation of clinical diseases of that organ.

Pathogenesis and Treatment of Renal Lithiasis — Newer Concepts. By Arthur J. Butt. Advances in Internal Medicine, Vol. VII, William Dock, I. Snapper, Editors, Chicago, The Year Book Publishers, Inc., 1955.

The investigation reported in this comprehensive article is discussed under the headings of: Mechanisms of Renal Calculus Formation; Effect of Testicular Hyaluronidase on Urine; Effect of Urinary Tract Infection on Urinary Colloids; Ground Substance Disturbance and Calculus Formation; and Hyaluronidase Therapy, with general considerations and clinical experience recounted.

The author concludes that decrease or change of the protective urinary colloids, by facilitating agglomeration of crystal-forming substances, may be one of the mechanisms in the pathogenesis of renal calculi. In selected cases, the protective colloid defect can be corrected by administration of hyaluronidase, which stimulates release of endogenous hyaluronic acid.

The suggestion is made that urine may be thought of as an extension of the extracellular ground substance, in particular because of its hyaluronic acid content. Infections, which affect the hyaluronic acid component, or endocrine changes, especially hyperfunction of the adrenal glands, would then have an adverse effect on the urine. On the basis of such a theory, it becomes possible to consider a common etiology for collagen diseases and renal calculosis. The etiologic factors would include infections, endocrine disturbances, and metabolic defects.

Extradural Hematoma of the Posterior Fossa: With Report of a Case. By Irwin Perlmutter, M.D., Richard E. Strain, M.D., and Rhoda Feinstein, B.A. South. M. J. 49:66-69 (Jan.) 1956.

The purpose of this paper is to report a case of cerebellar extradural hematoma and to describe the electroencephalographic findings. The importance of electroencephalography in head injury is emphasized anew with special reference to extradural hematoma of the posterior fossa.

Thirty-three cases of extradural hematoma of the posterior fossa reported in the literature are summarized in tabular form, consideration being given to the time elapsed between injury to operation and survival, injury to operation and death, and injury to death. The authors regard the rapidly increasing incidence of recovery in patients with this disease as due not only to improved surgical technics but to greater awareness of the condition. Prompt diagnosis and surgical intervention usually result in recovery. In the series reviewed, of the 24 patients subjected to surgery, 20 survived. Since there often is sufficient time for diagnostic study, the opportunity is afforded for the electroencephalogram to prove its value in the early recognition of this condition.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 1018, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

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Dedication Planned for Association's New Home

A beautiful new building, now nearing completion at 735 Riverside Avenue in Jacksonville, will soon become the permanent home of the Florida Medical Association. The dedication ceremony is planned for early next month.

Distinguished guests who have been invited to participate in the program include Dr. Dwight H. Murray, President of the American Medical Association, Governor LeRoy Collins, Senator Spessard L. Holland, Senator George A. Smathers and Dr. Wilson T. Sowder, State Health Officer.

The immediate past president of the Association, Dr. John D. Milton, of Miami, will preside, and the introductions will be made by Dr. William C. Roberts, of Panama City, President-Elect. Dr. Francis H. Langley, of St. Petersburg, President, will address the gathering and unveil the plaque.

An invitation will be extended to the entire membership of the Association to be present and to inspect the building. The public also will be invited to attend.

The formal dedication of this building will mark the culmination of efforts through the years to attain the goal of a home owned by the Association. Since its authorization by the 1955 House of Delegates, this major project has progressed rapidly under the able guidance of the Subcommittee on Housing of the Board of Governors, composed of Dr. Edward Jelks, chairman, Dr. Robert B. McIver and Dr. Samuel M. Day. The construction of a permanent home meets a pressing need for adequate space, assures the Association all the advantages of ownership, and also will result in appreciable financial savings.

Situated in the city where the Association was founded eighty-two years ago, the new home occupies a commanding site adjacent to the expressway system in the Riverside section and adjoining the State Road Department right of way at the approach to the recently completed bridge over the St. Johns River. The building is of contemporary design and of adequate size and arrangement to carry on the business of the Association now and in the foreseeable future.

The September dedicatory exercises will mark a major milestone in the progress of the Florida

The Association's new home was nearing completion as this issue of The Journal went to press. Formal dedication has been scheduled for September with Dr John D. Milton, of Miami, immediate past president, as the presiding officer. Introductions will be by Dr. William C. Roberts, of Panama City, President-Elect, and Dr. Francis H. Langley, of St. Petersburg, President, will deliver one of the principal addresses and unveil the plaque.

Medical Association. A large representation of the membership is expected to join with the officers and the Board of Governors in celebrating this happy event.

The Association's Group Income Protection Plan

The opportunity to take advantage of a sound plan of group disability insurance is now before the members of the Florida Medical Association. By qualifying during the charter enrolment period for participation in this plan, every member will do his part toward putting it speedily into successful operation. Thereby he will reap great personal benefit and at the same time enable the Association to join the large number of major local, state and national medical organizations which now have group disability plans.

The tremendous growth of the group insurance idea for professional organizations in recent years has resulted from the satisfaction given by plans similar to the one that has been worked out specially for the Association. Experience has proved the particular worth of the statewide plan with a membership large enough to insure stability and permanence without precluding local prompt service and close control.

The wisdom of putting such a plan into effect in Florida is demonstrated by the experience of Wisconsin physicians, 15 per cent of whom drew disability benefits during one year. "Here's a startling indication of the importance of disability insurance to medical men," states a news item in the May issue of Medical Economics. "In a recent twelve-month period, one out of every seven Wisconsin physicians covered by the state medical society's group disability insurance program availed himself of its benefits. The 259 practitioners who filed claims got from $37.50 to $75 a week, depending on the extent of their disability. Those confined to hospitals were paid an additional $10 a day for room and board, plus as much as $100 for all other expenses incurred during their stay."

The Association plan represents the culmination of many months of hard work by the Committee on Medical Economics under the leadership of Dr. Robert E. Zellner, and the prompt cooperation of every member will make this project an outstanding success. Prepared by Marsh & McLennan, of Atlanta, this plan is underwritten by Continental Casualty Company, of Chicago. Not usually available in group disability con-

tracts are several features, such as graded premium rates, optional two or five year coverage for sickness and lifetime for accident, and excess medical coverage at extra, but low, cost. Make the most of this unique opportunity to obtain or increase income protection. Help yourself, your family and your fellow members by mailing in your application today.

New "Medical Horizons" TV Series

The popular television series, "Medical Horizons," will return this fall for a minimum of 39 weeks on ABC-TV. The American Medical Association again will cooperate with Ciba Pharmaceutical Products, Inc., in presenting this medical documentary series of half-hour television programs, which will be featured at 4:30 p.m., New York time, on an 85 station national network of the American Broadcasting Company, beginning on Sunday, September 9. This greatly expanded network represents an increase from 42 stations which carried last year's program, and the greater length of the new series is in contrast to 26 weeks of the 1955-1956 series, presented each Monday evening from 9:30 to 10:00 p.m., New York time.

"Medical Horizons" will originate live from hospitals, medical schools and research institutions throughout the country. The show format will remain the same. Don Goddard, veteran newscaster, will return as narrator, and Dr. William T. Strauss will continue as medical supervisor.

The broadened scope of the 1956-1957 series is more fully appreciated in the light of the first series, in which "Medical Horizons'" cameras traveled over 11,000 miles to visit 26 medical centers in 20 cities located in 15 states and the District of Columbia. It was the most extensive series of remote telecasts ever attempted by any medical program.

Among the many interesting medical subjects presented in that series were the training of the medical student and the doctor, the work of the hospital nurse, the diagnosis and management of diseases of the liver, the use of the heart-lung bypass and the artificial kidney machine, the causes of headache, the effect of temperature and humidity on the human body, and the human factors in motor vehicle accidents. Some of the medical centers visited were the University of Pennsylvania, the Johns Hopkins University, the Cornell Medical Center, the Jersey City Medical Center, the Mayo Clinic, the Georgetown University, the Duke University, the University of St. Louis and the University of Colorado.

Commenting on the new 39 week series, T. F. Davies Haines, Ciba's president, said, "We trust that the greatly expanded coverage and continuity of the 1956-1957 series will inspire increased confidence in the American medical profession. We plan to have programs on advances in common everyday problems in medicine as well as on major diseases which as yet have not been fully conquered. The future of medicine looks bright, and we in the pharmaceutical industry are proud to have a part in the progress made toward better health."

Recommendations of State Polio Advisory Committee

The State Polio Advisory Committee met on May 13, 1956 at Miami Beach and established policies now effective in the use of Salk vaccine. The recommendations were:

1. The age groups eligible to receive Salk vaccine purchased with Federal funds should be increased to include ages 0 through 19 inclusive. However, it was the recommendation of the committee that vaccination of infants be deferred until they are six months of age.
2. All restrictions on age priority should be removed from vaccine distributed through commercial channels.
3. Third or booster injections should continue to be administered in Florida. This may be modified by local restrictions where the supplies of vaccine are insufficient to meet the demand for new, or first and second injections.
4. Injections of vaccine should continue during the summer months.
5. The program for evaluation of the vaccine for safety and effectiveness should be continued. For the practicing physicians this means that all cases of poliomyelitis or suspected cases occurring in vaccinated children, should be promptly reported to the local health officer. Specimens of stool and blood on these individuals should be obtained for virological studies. Instruction on collection of these specimens may be obtained from the health officer.

The committee strongly recommends that each physician continue to keep a record of all injections given, with information on the name, age, sex, race, site of injection, lot number and manufacturer. This information is required for the vaccine obtained from federal sources.

The committee also suggests that injections of commercial vaccine be recorded separately on the form, "Physicians Record of Individual Poliomyelitis Injections," and a copy sent to the County Health Officer with a notation—Commercial Vaccine. This information is important if an accurate surveillance for safety and effectiveness of the vaccine is to be maintained.

Florida's Salk Vaccine Supply

In order to make full use of the supplies of Salk vaccine now being received in Florida, physicians will be interested in the figures recently released by the Bureau of Preventable Diseases of the Florida State Board of Health. The tables which follow show the supplies received for the state's public distribution program and the Bureau's estimates of the number of eligible children who have been immunized as of May 30, 1956.

Supplies of Salk Vaccine Received in Florida For Public Distribution Program

Month	Cubic Centimeters
October, 1955	155,025
November	30,894
December	37,638
January, 1956	42,147
February	52,108
March	86,958
April	140,843
May	186,040
June (first week only)	163,927

Estimated Numbers of Children in Florida Who Have Received 1, 2 or 3 Injections of Salk Vaccine — May 30, 1956

Total Estimated Population 0-19	1,254,369	100 %
Estimated Number with 1 Injection	108,603	8.7%
Estimated Number with 2 Injections	273,562	21.8%
Estimated Number with 3 Injections	55,140	4.4%

Disability Freeze Information for Physicians

The members of the Advisory Committee to the Department of Health, Education and Welfare were responsible for establishing the medical standards for the determination of disability under the recent revision of the Social Security Act. It was also the responsibility of the Advisory Committee, to inform the profession of the results of their work so that physicians and patients would be able to utilize properly the provisions of the new law.

As a service to the profession, therefore, the Executive Committee of the Conference of Presidents and Other Officers of State Medical Associations has authorized the publication of the following statement:

In recent months many physicians have heard from patients about the disability freeze provision in the social security law. This provision, added to the old-age and survivors insurance program in 1954, permits people who have prolonged total disability to apply to have their social security records frozen for the period of their disability. Thus, the time when they could not work and so had no earnings credited to their social security accounts does not count against them in determining their rights to benefits, nor the amount of benefits which will be payable to them at age 65, or to their families in case they should die.

Before a worker's social security record can be frozen, he has to meet certain work requirements. His social security record up to the time of his disability must show that he was in fact a worker, with a fairly regular and recent work history. In addition, he must be shown to have a medically determinable physical or mental impairment severe enough to keep him from engaging in any substantial gainful activity — one which has existed for more than six months, and is expected to last indefinitely or end in his death.

Securing the Medical Evidence of Disability

The medical evidence needed to establish the nature and severity of the applicant's disability, the date it began, and its prognosis comes from the doctor who has treated the worker and knows his case, or the hospital or institution in which the worker has been confined. A Medical Report form was designed to assist the physician in furnishing the needed medical evidence and to indicate the nature and extent of clinical detail which would be necessary. It is given to the applicant for the "disability freeze" and he is asked to have it filled out by the physician most familiar with his impairment. The form itself is modeled closely after the medical report used by major life insurance companies in their disability claims work. In adapting it for use in the "freeze" program, the recommendations of a Medical Advisory Committee were closely followed. This Committee, composed of well qualified representatives of the medical and related nonmedical professions, gives advice and guidance to the Social Security Administration on the medical aspects of the "disability freeze" program.

If you have received this medical form to fill out for any of your patients, you are probably aware that the law makes the disabled worker responsible for seeing that medical evidence is submitted for him and for paying any costs involved. The law does not permit the Government to pay any costs in connection with securing the medical evidence needed for a determination of disability. You may also know that to insure the confidentiality of the medical evidence, the medical report

form is not to be returned to the patient, but is to be mailed by the physician direct to the local social security office. This office, incidentally, is ready to furnish additional information to the physician concerning the medical report form and the operation of the disability freeze.

Determining Disability

Determinations as to disability based on the evidence submitted are made under an agreement with the Federal Government, by professional members of an agency of the State in which the applicant resides. In most States, this is the vocational rehabilitation agency. Since referral of disabled individuals for any rehabilitative services which might return them to gainful work is an important aspect of the program, each person applying for the social security disability freeze is told about the availability of vocational rehabilitation services.

On the professional team in the State agency at least one member is a doctor of medicine. The team reviews and evaluates all medical evidence assembled in the applicant's file, as well as such non-medical factors as age, education and occupational experience. Certain medical guides and standards, worked out with the advice of the Medical Advisory Committee are used in the consideration of the medical evidence. But, although these guides and standards can be applied in most cases, they are not rigid and arbitrary. The final determination in each case is based on all the available facts on the individual's impairment and vocational history, and, there is consultation among physicians in any borderline situation.

Guides to Filling Out the Medical Report Form

No matter how good the standards, nor how considered the judgment of the reviewing team, the determination reached can be no sounder than the evidence upon which it is based. To make sure that he is providing sufficient medical evidence for a prompt and fair determination, the doctor will want to consider the following guides in filling out medical report forms for those of his patients who have applied for the social security disability freeze:

First, include sufficient clinical detail to enable the reviewing team to make a sound determination as to the severity and extent of the patient's current condition;

Second, give enough of the clinical history to provide information as to when the disability began, and when it became so severe as to keep the patient from working;

Third, describe the probable course of the condition from now on, so that a decision can be reached as to whether the impairment is likely to continue indefinitely, or end in death, or whether it is self-limiting, or remediable in the foreseeable future.

Graduate Medical Education

Short Course and Gastroenterology Seminar Held

The Twenty-Fourth Annual Graduate Short Course, held at the George Washington Hotel in Jacksonville the week of June 25-29, was well attended and the lectures were enthusiastically received. It can be said without exaggeration that the lecturers have never been more highly complimented for their presentations than they were at this year's course. The subjects were chosen and the lectures were designed primarily to interest the general practitioner; they were comprehensive and covered the latest advances in the respective fields.

The members of the faculty were Dr. James V. Warren, Professor of Medicine, Duke University School of Medicine, Durham, N. C., Medicine; Dr. James G. Hughes, Professor of Pediatrics, University of Tennessee School of Medicine, Memphis, Tenn., Pediatrics; Dr. Paul V. Lemkau, Director, Mental Health Service, New York Committee of Mental Health Board, New York, Psychiatry; Dr. Howard W. Jones Jr., Assistant Professor of Gynecology, The Johns Hopkins School of Medicine, and Dr. Georgeanna Jones, The Johns Hopkins Hospital, Baltimore, Gynecology; and Dr. William R. Sandusky, Associate Professor of Surgery, School of Medicine, University of Virginia, Charlottesville, Va., Surgery.

The Seminar on Gastroenterology which immediately preceded the Short Course this year was also held at the George Washington Hotel in Jacksonville. It began on June 21 and continued for three days. The attendance was comparable to that of previous years, and keen interest was manifested in the lectures. The course was presented by Dr. David Cayer, Professor of Gastroenterology, The Bowman Gray School of Medicine, Wake Forest College, Winston-Salem, N. C., and Dr. E. Clinton Texter Jr., Associate Professor of Medicine and Director of the Gastroenterology Laboratory, Northwestern University Medical School, Chicago.

Both the Short Course and the Seminar on Gastroenterology were presented by the Division of Postgraduate Education of the College of Medicine of the University of Florida, the Florida State Board of Health and the Florida Medical Association.

1957 Short Course in Gainesville

The Committee on Medical Postgraduate Course of the Florida Medical Association decided at its recent meeting that the 1957 Annual Graduate Short Course and the seminar which customarily precedes it will be held in Gainesville. The dates for these meetings will be approximately the same as those for this year and preceding years.

Diabetes Seminar October 18-19, 1956

A Seminar on Diabetes Mellitus will be held at the Duval Medical Center in Jacksonville on October 18 and 19, 1956. In the outpatient de-

partment of the Center approximately 400 patients with active disease attend the special diabetes clinic. During the Seminar a clinical conference will be held, and clinical material will be available to all speakers who desire to utilize it. The Florida Clinical Diabetes Association will hold its fourth annual meeting at the same time. Any Florida physician who desires to attend may register for this meeting and enter his expenses as a deductible item on his income tax return.

Report of Florida Delegates to American Medical Association 1956 Annual Meeting

Hospital accreditation, evaluation of graduates of foreign medical schools, private practice by medical school faculty members, federal aid to medical education and premature publicity on new drugs were among the major subjects acted upon by the House of Delegates at the American Medical Association's 105th Annual Meeting held June 11 to 15 in Chicago.

Dr. David B. Allman, surgeon of Atlantic City, N. J., was named unanimously as president-elect for the coming year. A member of the A. M. A. Board of Trustees since 1951 and also chairman of the Committee on Legislation, Dr. Allman will become president of the American Medical Association at the June 1957 meeting in New York City. He will succeed Dr. Dwight H. Murray of Napa, Calif., who took office at the Tuesday evening inaugural program in the Chicago Civic Opera House.

The House of Delegates selected Dr. Walter L. Bierring of Des Moines, Iowa, as recipient of the 1956 Distinguished Service Award of the American Medical Association for his long and outstanding contributions to medicine and humanity. Dr. Bierring, a past president of the A. M. A., was honored for his achievements in the fields of public health and medical examining board work. He formally accepted the award at the Tuesday inaugural program.

Total registration at the end of the fourth day of the meeting, with half a day still to go, had reached 22,394, including 9,793 practicing physicians and 12,601 residents, interns, medical students and guests.

Hospital Accreditation

The House of Delegates approved the report of the Committee to Review the Functions of the Joint Commission on Accreditation of Hospitals, which was appointed by the Speaker as a result of action taken at the June 1955 meeting. The Committee came to the following conclusions:

"1. Accreditation of hospitals should be continued.

"2. The Joint Commission should maintain its present organizational representation.

"3. The Board of Trustees should report annually to the House of Delegates on the activities of the Joint Commission.

"4. Physicians should be on the administrative bodies of hospitals.

"5. General practice sections in hospitals should be encouraged.

"6. Staff meetings required by the Joint Commission are acceptable, but attendance requirements should be set up locally and not by the Commission.

"7. The Joint Commission should not concern itself with the number of hospital staffs to which a physician may belong.

"8. The Joint Commission is not and should not be punitive.

"9. The Joint Commission should publicize the method of appeal to hospitals that fail to receive accreditation.

"10. Reports on surveys should be sent to both administrator and chief of staff of hospital.

"11. Surveyors should be directly employed and supervised by the Joint Commission.

"12. Surveyors should work with both administrator and staff.

"13. New surveyors should receive better indoctrination.

"14. Blue Cross and other associations should be requested not to suspend full benefits to non-accredited hospitals until those so requesting have been inspected.

"15. The American Medical Association should conduct an educational campaign for doctors relative to the functions and operations of the Joint Commission.

"16. The Committee also suggests that the American Medical Association and the American Hospital Association encourage educational meet-

ings for hospital boards of trustees and administrators either on state or national levels to acquaint these bodies with the functions of accreditation.

"17. This Committee asks to be discharged upon submission of this report to the House of Delegates."

The House also approved a reference committee suggestion that the following statement be added to strengthen the report:

"The Committee recommends that the commissioners to the Joint Commission on Accreditation of Hospitals, appointed by the Board of Trustees of the American Medical Association, urge that Commission to study:

"1. The problems of the exclusion from hospitals and arbitrary limitation of the hospital privileges of the general practitioner, and

"2. Methods whereby the following stated principles may be achieved:

" 'The privileges of each member of the medical staff shall be determined on the basis of professional qualifications and demonstrated ability.'

" 'Personnel of each service or department shall be qualified by training and demonstrated competence, and shall be granted privileges commensurate with their individual abilities.' "

Graduates of Foreign Medical Schools

The House of Delegates approved in principle a program for the evaluation of graduates of foreign medical schools seeking hospital positions in the United States. The proposed program was developed by the Cooperating Committee on Graduates of Foreign Medical Schools, representing the A. M. A. Council on Medical Education and Hospitals, American Hospital Association, Association of American Medical Colleges and Federation of State Medical Boards of the United States.

The following principles were emphasized by the Council on Medical Education and Hospitals in its report recommending A M. A. participation in the program:

"1. Although the responsibility to share educational opportunities in medicine is recognized, the primary concern must be for the health care of the American public. Thus, before assuming responsibility for the care of patients as interns or residents, all graduates of foreign medical schools (immigrants, exchange students and American graduates of foreign medical schools) should give evidence, as nearly as can be measured, of having reached a level of educational attainment comparable to that of students in American schools at the time of graduation.

"2. The primary objective of this Committee is to devise an effective mechanism for measuring educational attainment in the absence of intimate and continuing knowledge of the educational background of foreign-trained physicians. This mechanism should provide hospitals with pertinent information regarding the medical qualifications of foreign-trained physicians seeking positions as interns or residents. It should not interfere with the hospital's privilege of making its own selection among qualified physicians, nor should it serve as a substitute for or interfere with the normal licensure procedures of the various state boards.

"3. It is not intended that this mechanism be applicable to those foreign medical school graduates in this country as temporary students participating in programs of medical and related studies in recognized universities, medical schools and postgraduate schools, who by the very nature of their study are not involved in the responsibility of patient care."

The proposed plan calls for establishment of a central administrative organization to evaluate the medical credentials of foreign-trained physicians desiring to serve as interns or residents in American hospitals. Basic requirements would include satisfactory evidence of at least 18 years of total formal education, including a minimum of 32 months in medicine exclusive of any time which in this country would be considered as premedical study or internship. Applicants with satisfactory credentials then would take a screening examination to determine their medical knowledge and their facility with the English language. Successful applicants then would be certified to hospitals and other interested organizations, with the approval of the foreign-trained physician concerned.

Private Practice by Medical School Faculty Members

Another major action by the House involved the problem of private practice by medical school faculty members, which has been under study by the Committee on Medical and Related Facilities of the Council on Medical Service. The House adopted a Council report which stated "that it shall be the policy of the American Medical Association that funds received from the private practice of medicine by salaried members of the clinical faculty of the medical school or hospital should not accrue to the general budget of the

institution and that the initial disposition of fees for medical service from paying patients should be under the direct control of the doctor or doctors rendering the service."

It was further recommended that adequate liaison be developed and maintained between each county medical society and any medical school or schools in its area; that the Council on Medical Education and Hospitals and the Association of American Medical Colleges urge all medical schools to assist and work with medical societies in developing such liaison, and that publicity emanating from a medical school should be in good taste and of a type which has the approval of the general medical community in that area.

The adopted report also said: "It is not in the public or professional interest for a third party to derive a profit from payment received for medical services, nor is it in the public or professional interest for a third party to intervene in the physician-patient relationship."

Federal Aid to Medical Schools

One of the most controversial subjects of debate on the floor of the House was a resolution expressing strong opposition to S. 1323, a bill in Congress providing for one-time, matching grants to medical schools for construction purposes. The Association in recent years has been supporting such legislation in principle, with certain reservations concerning details of some provisions. The House reaffirmed that policy by approving a reference committee statement which said:

"We appreciate the intent with which this resolution was introduced, but at the same time we feel that there are many economic and geographical factors involved, which might not make this resolution practical on a national level. Inasmuch as no evidence was offered to this Committee to justify a change in the previously declared policy of the House of Delegates, your Committee recommends that this resolution be not adopted."

Premature Drug Publicity

The House adopted a substitute resolution which read:

"Whereas, In recent years, events have indicated the necessity for a closer liaison between the pharmaceutical manufacturer and the American Medical Association; and

"Whereas, In view of the tremendous number of new drugs being developed and the expanding research programs in medical colleges, clinics and hospitals being financed by the drug industry, it is imperative that the manufacturer and the medical profession develop cooperatively guiding principles which will protect the American people from being subjected to the premature release of information pertaining to new products or techniques; and

"Whereas, Competition within the pharmaceutical industry has become extremely keen so that in the advertising of their products drug manufacturing firms have been forced into the expenditure of larger and larger sums of money and in increasingly broader fields of advertising; therefore be it

"Resolved, That the Board of Trustees of the American Medical Association appoint a liaison committee to meet with representatives of the pharmaceutical manufacturers to accomplish this objective."

Miscellaneous Actions

Among many other actions on a wide variety of subjects, the House also:

Approved a Board of Trustees statement on Social Security which included the following: "It is imperative that we distinguish clearly between this problem of coverage of physicians and the far more dangerous disability proposal. The fact should be recognized that the shape of medical practice in the future is not directly related to the inclusion or exclusion of physicians under OASI. It is a matter of vital importance to us as individuals, but it cannot, per se, stimulate further government intrusion into medical care. On the other hand, the disability amendment obviously brings the Social Security Administration closer to the regulation of medical care than ever before."

Adopted a resolution amending the Bylaws to provide that the Vice President, Treasurer, Speaker and Vice Speaker of the House of Delegates shall be ex officio members of the Board of Trustees with all the rights and duties of the Board without the right to vote.

Increased membership of the Council on Medical Service from six to nine active or service members and eliminated all ex officio members except the immediate Past President.

Directed the Council on Medical Service and the Council on Industrial Health to reconsider the "Guiding Principles for Evaluating Management and Union Health Centers" through their joint Committee on Medical Care for Industrial Workers and to so revise the guides that they conform completely with the Principles of Medical Ethics. *(Continued on page 176)*

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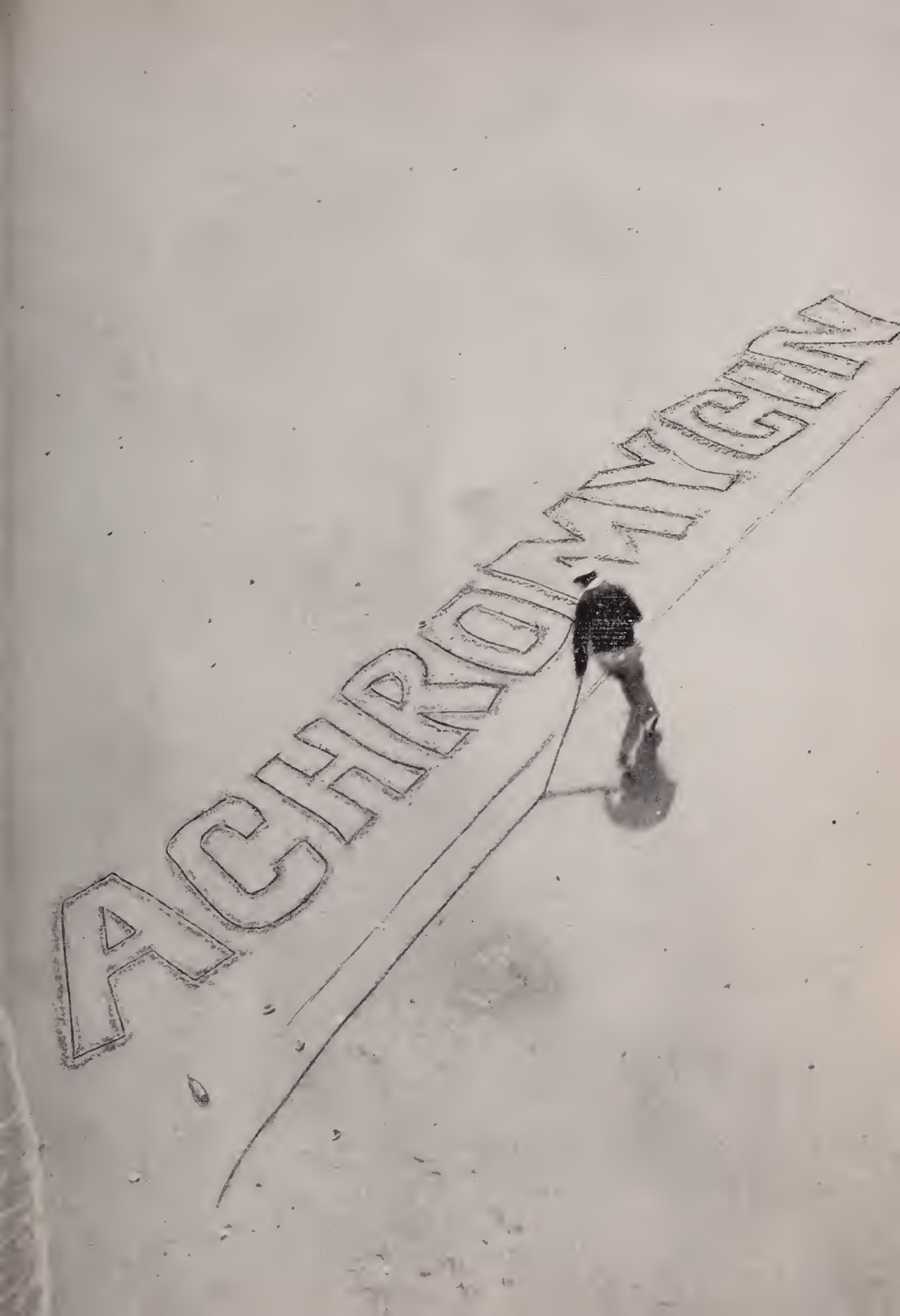
ACHRONYCIN

(Continued from page 173)

Authorized the Committee on Federal Medical Services to make a continuing study of all aspects of VA medical activities under the basic policy established in June 1953 and suggested reconsideration of the temporary exceptions made at that time with respect to neuropsychiatric and tuberculous disorders.

Recommended that the Board of Trustees select New York City as the place of the 1961 annual meeting.

Opening Session

At the Monday opening session Dr. Elmer Hess, outgoing A. M. A. President, warned that the medical profession must be prepared to face an all-out drive by some labor groups for national compulsory health insurance. Dr. Dwight H. Murray, then President-Elect, told the House that general practitioners and specialists must guard against "any cleavage within our profession," and he urged strength through unity.

Dr. Lowell T. Coggeshall, special assistant to Secretary Marion B. Folsom of the U. S. Department of Health, Education, and Welfare, assured the House that the over-all medical objectives of HEW are in accord with those of the A. M. A. A memorial plaque honoring the late Dr. Carl M. Peterson, secretary for 17 years of the A. M. A. Council on Industrial Health, was presented by Dr. Ross McIntire on behalf of the President's Committee on Employment of the Physically Handicapped. The Illinois State Medical Society presented a check for $164,940 to the American Medical Education Foundation.

Inaugural Program

Dr. Murray, in his inaugural address at the Tuesday evening ceremony in the Chicago Civic Opera House, declared that "what we need most in medicine today is to find some way of combining modern scientific methods with the personal, friendly touch of the old-time family doctor." The inaugural program, which included the Bluejacket Choir of the U. S. Naval Training Center at Great Lakes, Ill., was telecast over Station WBKB in Chicago.

Election of Officers

In addition to Dr. Allman, the new President-Elect, the following officers were elected:

Dr. F. S. Crockett of Lafayette, Ind., Vice President; Dr. George F. Lull of Chicago, Secretary; Dr. J. J. Moore of Chicago, Treasurer; Dr. E. Vincent Askey of Los Angeles, Speaker, and Dr. Louis M. Orr of Orlando, Fla., Vice Speaker.

Dr. Julian Price of Florence, S. C., was reelected to the Board of Trustees, and Dr. Hugh Hussey of Washington, D. C., was named to succeed Dr. Allman. Dr. Robertson Ward of San Francisco was elected to the Judicial Council to succeed Dr. Walter F. Donaldson.

Re-elected to the Council on Medical Education and Hospitals were Dr. Guy A. Caldwell of New Orleans and Dr. John W. Cline of San Francisco. Dr. Walter E. Vest of Huntington, W. Va., was named to succeed Dr. Louis A. Buie on the Council on Constitution and Bylaws.

Elected to the Council on Medical Service were Dr. Carlton Wertz of Buffalo, N. Y., to succeed himself, and Dr. J. F. Burton of Oklahoma City to succeed the late Dr. A. C. Scott, Jr. of Texas. Named for the three new places created on the Council on Medical Service were Dr. Thomas Danaher of Torrington, Conn.; Dr. R. M. McKeown of Coos Bay, Ore., and Dr. Lafe Ludwig of Los Angeles.

Respectfully submitted,
Louis M. Orr, M.D.
Reuben B. Chrisman Jr., M.D.
Francis T. Holland, M.D.

Registration

Total registration of Florida Medical Association members at the 1956 A. M. A. annual meeting in Chicago was 76. Members in attendance were:

BRADENTON: Lowrie W. Blake. CALLAHAN: David D. Bennett Jr. CORAL GABLES: W. A. D. Anderson, Reuben B. Chrisman Jr., Howard C. McDevitt Jr., James K. McShane, Louis C. Skinner Jr. CRYSTAL RIVER: Samuel R. Miller Jr. DANIA: Fred E. Brammer. DAYTONA BEACH: David W. Goddard. FERNANDINA BEACH: Henry B. Dickens Jr. FORT LAUDERDALE: Benjamin F. Hart, Richard A. Mills, John I. Williams, Scottie J. Wilson. JACKSONVILLE: Lee E. Bransford Sr., Gordon H. Ira, Aaron Z. Oberdorfer, Lorenzo L. Parks, Wilson T. Sowder. KISSIMMEE: Lois E. Friedl. LAKELAND: Robert M. Akey. LAKE WORTH: Sidney Davidson. MIAMI: Milton M. Coplan, Carl H. Davis, M. Eugene Flipse, M. Jay Flipse, Harold S. Kaufman, Morris E. Kuckku, Robert B. Lawson, George D. Lilly, E. Sterling Nichols, Mary C. Patras, Homer L. Pearson Jr., William C. Phillips, Lyle W. Russell, Ralph S. Sappenfield, George F. Schmidt Jr., Edwin W. Troutman, Louis J. Wisch. MIAMI BEACH: Theodore M. Berman, Jacob A. Glassman, Abraham R. Hollender, Alexander Libow, Paul Plotkin, Maurice J. Rose, Efton J. Thomas, Robert J. Trope. NAPLES: Earl S. Davis. OCALA: William J. McGovern. ORLANDO: Edward T. Furey, Frank D. Gray, Charles C. Hall, William H. Kelley, Louis M. Orr, W. Dean Steward. ROCKLEDGE: James R. Doty, John C. Miethke. ST. AUGUSTINE: Vernon A. Lockwood. ST. PETERSBURG: Arnold S. Anderson, Walter H. Bailey, Robert M. Kilmark, James K. McCorkle. SARASOTA: Laurence W. Gregory, Thomas R. Young Jr. TALLAHASSEE: Francis T. Holland. TAMPA: Frank S. Adamo, H. Phillip Hampton, Alfonso F. Massaro, Thomas F. Nelson, James N. Patterson, Burdette Smith. VERO BEACH: Vernon L. Fromang. WEST PALM BEACH: Theodore F. Gerson. WINDERMERE: James R. Reuling. WINTER PARK: Walter B. Johnston.

New Religion and Psychiatry Organization

Dr. Kenneth E. Appel, of Philadelphia, recently announced formation of the National Academy of Religion and Mental Health. Dr. Appel, the president of the new organization, is also president this year of the Joint Commission on Mental Health, which was founded by the American Medical Association and seven other national organizations.

This is not the first cooperative project between the fields of religion and mental health, but the present endeavor has the broadest representation. In a statement explaining the purposes of this latest concerted effort, Dr. Appel said:

"The national academy will provide opportunities for study in the relationships between religion, morality, and mental health. Because morality is an essential ingredient in personality development, morality is brought into direct relationships with clinical medicine. There is need to explore these relationships particularly in the light of new developments in psychiatry, psychology, and the behavioral sciences."

First Inter-American Conference on Occupational Medicine and Toxicology Miami, Sept. 3-7, 1956

The University of Miami, School of Medicine, jointly with the University of Havana, School of Medicine, Cuba, will hold this year the first inter-American Conference on Occupational Medicine and Toxicology. The meeting will be held September 3 to 7. The official language of the program will be Spanish.

This year the conference will be held in Miami with the University of Miami, School of Medicine, serving as host. It is expected that this conference will be repeated next year with the University of Havana, School of Medicine, serving as host.

The program is in the hands of a committee from these two universities. General Chairman of this year's meeting is Dr. Homer F. Marsh, Dean of the School of Medicine of the University of Miami. Co-chairmen for the University of Miami are Dr. Ralph Jones Jr., Professor of Medicine, Dr. Willard Machle, Research Associate Professor of Pharmacology, and Dr. William B. Deichmann, Professor of Pharmacology. The committee of the University of Havana includes the following: Dr. Angel Peres André, Acting Dean (Vice Dean), Dr. Rafael Penalver, Instructor in Legal Medicine and Toxicology, Dr. Vicente Pardo Castello, Assistant Professor of Dermatology, and Dr. Francisco Lancis y Sanchez, Assistant Professor of Legal Medicine and Toxicology.

On the program are speakers from Venezuela, Mexico, Peru, Colombia, Chile, Puerto Rico, Cuba and the United States.

Papers to be presented cover such topics as: "Establishment of a Medical Department in Industry," "Work and Fatigue in Industry," "Effects of Environmental Conditions on the Health of the Occupational Worker," "Recording of Medical Case Histories," "Control of Malaria in Endemic Areas," "Occupation and Heart Disease," "The Role of the Anesthesiologist in Acute Poisonings," "Neurological Problems in Occupational Medicine and Toxicology," "The Treatment of Intoxications by Organic Phosphates," "Management of Berylliosis," and "Treatment of Manganese Intoxications."

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INTERNIST: Certified by American Board of Internal Medicine—experienced in private practice—wishes to affiliate with Internist or group. Write 69-190, P.O. 1018, Jacksonville, Fla.

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FOR RENT: Excellent offices for physician in Lakewood, growing suburb of South Jacksonville, Fla. Terrazo floors. Heated. Air conditioned. Two rest rooms. Ample parking facilities. Write 69-192, P.O. Box 1018, Jacksonville, Fla.

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GENERAL PRACTITIONER: Wanted for group practice in Dade-Broward area. Write 69-194, P.O. Box 1018, Jacksonville, Fla.

WANTED: Otolaryngologist, EENT or Psychiatrist for new St. Nicholas Medical Center. Located conveniently to all Jacksonville by public and private transportation. Balanced clinic with exception of above specialties. Only one suite available in building. Janitor and maid service. Air conditioned. All utilities furnished except telephone. W. G. Allen Jr., EX 8-5500, 3116 Atlantic Blvd., Jacksonville, Fla.

FOR SALE MIAMI: Diagnostic and Treatment Clinic with investment income property included. Central location all hospitals. Will accommodate group if desired. Adaptable to easy conversion. Excellent financing reliable purchasers only. Write 69-195, P.O. Box 1018, Jacksonville, Fla.

GENERAL PRACTITIONER: Wanted to associate with same, Suburban Jacksonville Clinic-Hospital. Preferably experienced. No disinclination for O.B. Percentage with minimum guaranteed. Write 69-196, P.O. Box 1018, Jacksonville, Fla.

WANTED: General Practitioner or Internist to fill vacancy in South Central Florida. Unusual opportunity to get quickly established without great expense. Write for appointment or interview. Write 69-197, P.O. Box 1018, Jacksonville, Fla.

COMPONENT SOCIETY NOTES

Broward

"Mental Health — A Community Responsibility" was the topic of the panel discussion featured at the May meeting of the Broward County Medical Association. Speakers on the panel were Drs. Rudolph W. Heath, Jess V. Cohn, George P. Dunlevy Jr. and Robert E. Mills.

Members of the Woman's Auxiliary to the Association were invited guests for the meeting held in the Public Health Building.

Hillsborough

Dr. Frank Cline Jr., medical director of the Southwest Florida Tuberculosis Hospital, and his staff presented the scientific program of the June meeting of the Hillsborough County Medical Association. Dr. Cline was principal speaker. The title of his address was "Recent Advances in the Therapy of Tuberculosis." The meeting was held in the Hospital.

Jackson-Calhoun

The annual scientific meeting of the Jackson-Calhoun County Medical Society was held early in May in the Jackson County Health Department Building at Marianna.

Drs. Bruce Logue and Spalding Shroder of the Emory University School of Medicine were principal speakers. The subject of Dr. Logue's address was "Cardiac Emergencies" and Dr. Shroder discussed "Kidney Disease as a Cause of Hypertension."

BIRTHS AND DEATHS

Births

Dr. and Mrs. Charles D. Cooksey, of Jacksonville, announce the birth of a daughter, Suzan Elizabeth, on March 25, 1956.

Dr. and Mrs. James J. Hutson, of Miami, announce the birth of a daughter, Margaret Alice, on March 14, 1956.

Dr. and Mrs. William A. Pacetti Jr., of Coral Gables, announce the birth of a daughter, Valerie Susan, on March 19, 1956.

Dr. and Mrs. Lynn P. Carmichael, of Miami, announce the birth of a son, John Kevin, on May 3, 1956.

Dr. and Mrs. Donald G. Stannus, of Miami, announce the birth of a daughter, Laurie Joan, on March 12, 1956.

Dr. and Mrs. Stephen C. Wright, of Miami, announce the birth of a son, Bradford Collins, on March 20, 1956.

Drs. William W. Waring and Nell P. W. Waring, of Jacksonville, announce the birth of a son, Benjamin Joseph, on April 26, 1956.

Deaths—Other Doctors

Chandler, James R. Sr., Daytona Beach ..... April 8, 1956
Tompkins, Charles Wilmer,
Address Unknown ..... December 31, 1948

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Lynn P. Carmichael, Miami
Albert W. Clark, Jacksonville
Richard E. Dalrymple, Warrington
Clarence H. Houston, Jacksonville
John W. Jolley, Delray Beach
Jack Kartub, McIntosh
Leon E. Kresler, Winter Park
James G. Lyerly Jr., Jacksonville
Paul L. Mahoney Jr., Jacksonville
Donald M. Mosher, Melbourne
Mervin H. Needell, Miami
Jack H. Raulston, Boynton Beach
Alex F. Sanchez, Plant City
Louis W. Schneider, Miami
John H. Terry, Belleaire, Texas
Bernard Tumarkin, Coral Gables
David P. Wollowick, Safety Harbor
John E. Wright, Miami

STATE NEWS ITEMS

A tentative program has been released for the 1956 Tri-State Obstetric-Pediatric Seminar scheduled for Sept. 10-12 in the Daytona Plaza Hotel at Daytona Beach.

The list of speakers includes Dr. William J. Dieckmann, Professor of Obstetrics and Gynecology, School of Medicine, University of Chicago; Dr. Sydney Gellis, Associate Professor of Pediatrics, The Harvard Medical School; Dr. Charles H. Hendricks, Associate Professor of Obstetrics and Gynecology, Western Reserve University School of Medicine; Dr. James G. Hughes, Professor of Pediatrics, University of Tennessee College of Medicine; Dr. Milton L. McCall, Professor of Obstetrics and Gynecology, Louisiana State University School of Medicine; Dr. Howard W. Jones Jr., Assistant Professor of Obstetrics and Gynecology, Johns Hopkins University School of Medicine; Dr. Georgeanna Jones, Assistant Professor of Gynecology, Johns Hopkins School of Medicine; Dr. Robert B. Lawson, Professor of Pediatrics, University of Miami School of Medicine; Dr. John Parks, Chairman, Department of Obstetrics and Gynecology, George Washington University School of Medicine, and Dr. Edith Potter, Associate Professor of Pathology, School of Medicine, University of Chicago.

Dr. Herbert Eichert of Miami was elected vice president of the American College of Cardiology at the recent annual meeting held in Chicago.

Dr. Warren G. Darty of Palmetto has been presented the Manatee County Shrine Club's award for courteous driving during the month of May.

Dr. Willard F. Ande of West Palm Beach was principal speaker at the recent meeting of the Youth Conservation Department of the Woman's Club of that city. The subject of his address was cancer detection and prevention.

Dr. Samuel R. Warson of Sarasota discussed "The Problem of Anxiety" before the Unitarian-Universalist Fellowship of the city at a meeting held recently at the Community House.

Dr. Jack Q. Cleveland of Coral Gables has been appointed general chairman of local arrangements for the first Pan American Cancer Cytology Congress being held in Miami next year.

Dr. William P. Hixon of Pensacola has been elected president of the Florida Heart Association to succeed Dr. Victor H. Kugel of Miami Beach. Dr. Milton S. Saslaw of Miami has been chosen president-elect and Dr. Herbert Eichert also of Miami executive vice president.

Dr. Douglas R. Murphy of Venice was principal speaker at a recent meeting of the Venice-Nokomis Rotary Club held at Venice. The subject of his address was the methods of treating fractures.

Dr. Allen Y. DeLaney of Gainesville has been elected president of the Alachua County Tuberculosis and Health Association.

Dr. James W. Sapp of Havana has been elected a Fellow in the Southeastern Surgical Congress. The Certificate of Fellowship will be awarded Dr. Sapp at a meeting of the Congress next year in St. Petersburg.

Dr. John D. Browning of Fort Pierce has been elected president of the Florida Council for Retarded Children.

Drs. James B. Leonard and Percy H. Guinand of Clearwater explained the pathological facilities of Morton Plant Hospital at a recent meeting of the Rotary Club of the city.

Dr. James J. Griffitts of Miami has been elected president of the Florida Association of Blood Banks. Dr. John B. Ross of Jacksonville has been chosen president-elect and Dr. Gretchen V. Squires of Pensacola vice president.

Dr. A. Louis Girardin Jr. of Fort Myers has returned from Philadelphia where he attended a short course in pediatrics at Philadelphia Children's Hospital.

Dr. DeWitt C. Daughtry of Miami has been elected a director-at-large from Florida of the National Tuberculosis Association.

Dr. William H. Grace of Fort Myers has been awarded a 50 year diploma by Tulane University School of Medicine from which he was graduated

in 1906. The ceremony took place during the School's recent graduation exercises.

Dr. Bernard F. O'Hara of West Palm Beach has been elected a Fellow in the American Academy of Pediatrics.

Dr. Richard A. Henry of Brooksville has returned from Baltimore where he has been doing postgraduate work in gynecology at the Johns Hopkins Hospital.

Dr. Alvan G. Foraker of Jacksonville has been promoted to the grade of senior surgeon in the reserve of the U. S. Public Health Service.

Dr. Richard E. Strain of Miami was one of the speakers at the annual meeting of the Harvey Cushing Society held recently in Honolulu. The title of his paper was "Hemiballismus Relieved by Ventral Quadrant Section of the Cervical Spinal Cord Without Paralysis." In the golf tournament held during the meeting, Dr. Strain won the prize for low net score.

Dr. Maurice I. Edelman of Miami Beach has announced the opening of an office at 2212 Biscayne Boulevard, Miami, for the practice of ear, nose, throat and plastic surgery.

Dr. James N. Patterson of Tampa has returned from Chicago where he attended an interim meeting of the American Board of Pathology.

The Thirty-Eighth Annual Session of the American College of Physicians has been scheduled for Boston, Mass., April 8-12, 1957, according to announcement by Dr. Richard P. Stetson of Boston, general chairman for the meeting.

Dr. Jack A. Sloane of Miami has been appointed assistant chief of urology at the Second General Hospital, Landstuhl, Germany, with the rank of major.

The American College of Gastroenterology has announced that its annual postgraduate course in gastroenterology is scheduled for October 18-20, 1956, at The Roosevelt in New York City. The course will be under the direction of Dr. Owen H. Wangensteen, Professor of Surgery of the University of Minnesota Medical School. Information may be obtained by writing the College, Department P.G., 33 West 60th Street, New York 23.

Dr. M. Jay Flipse of Miami has been reelected regent for Florida, Georgia and the Carolinas of the American College of Chest Physicians. Dr. Arnold S. Anderson of St. Petersburg will continue to serve the College as governor for Florida.

Dr. Milton S. Saslaw of Miami and Dr. W. Dean Steward of Orlando have been elected Fellows in the American College of Chest Physicians.

Drs. Homer L. Pearson Jr. of Miami; Madison R. Pope of Plant City, and Erasmus B. Hardee of Vero Beach have been reappointed to the State Board of Medical Examiners by Governor LeRoy Collins.

Dr. Walter W. Sackett Jr. of Miami has returned from Tyronza, Ark., where he attended a meeting of the Tri-County Medical Association. One of the most unique medical gatherings in the world, the one day meeting was attended by the presidents of the American Medical Association, the American Dental Association, the American Pharmaceutical Association, the deans of three medical schools and many distinguished personalities in medicine among whom were Drs. Walter Alvarez and Robert Greenblatt.

Dr. James G. Lyerly of Jacksonville attended the annual meeting of the Harvey Cushing Society held recently in Honolulu.

Dr. Phillip W. Horn of Jacksonville has been elected a member of the executive committee of the Duval County Tuberculosis Association. New Board members are Drs. Augustus E. Anderson

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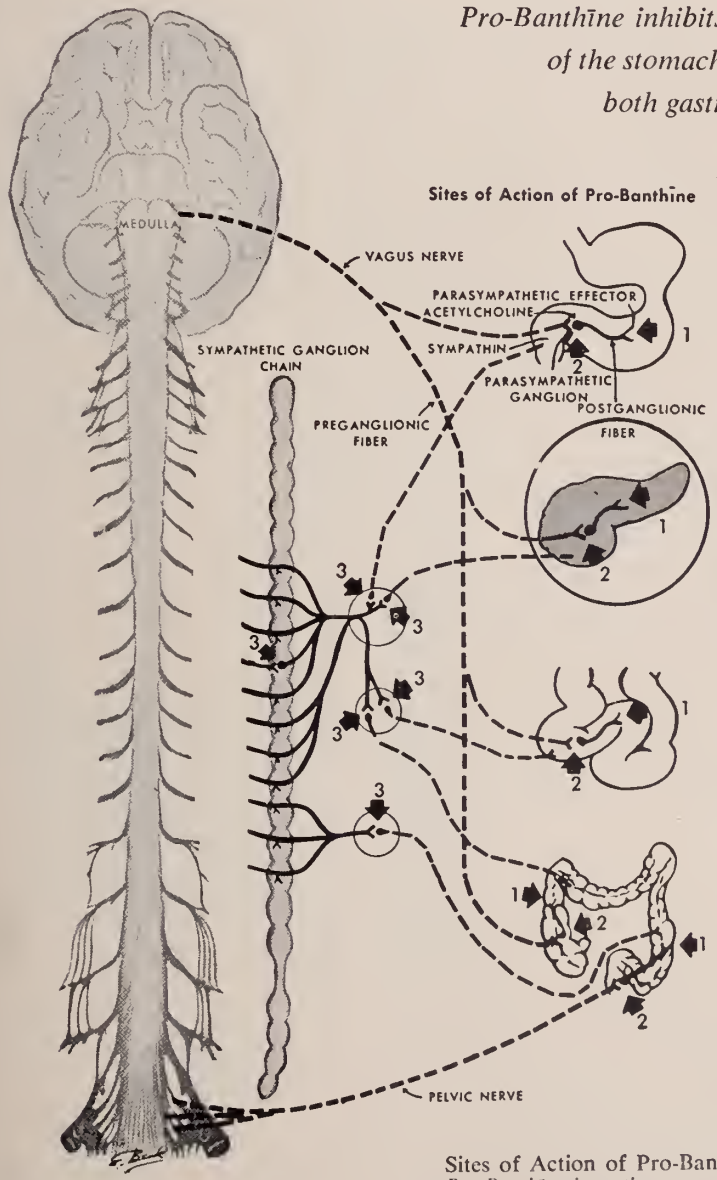

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1. Jones, C. A.: Arch. Int. Med. *96*:332 (Sept.) 1955.
2. Zollinger, R. M.: Postgrad. Med. *15*: 323 (April) 1954.
3. Woodward, E. R.: M. Clin. North America *38*:115 (Jan.) 1954.
4. Schwartz, I. R., and Hinton, J. W.: Personal communication, February, 1955.

Sites of Action of Pro-Banthīne. *The principal site of action of Pro-Banthīne is on the parasympathetic system where it exerts a dual action while exerting a single and lesser action on the sympathetic system: (1) parasympathetic effector; (2) parasympathetic ganglion; (3) sympathetic ganglion (see arrows).*

SEARLE

Jr., Edward Canipelli and Marvin H. Johnston, all of Jacksonville.

Dr. Jack O. W. Rash of Miami has returned from Atlantic City where he attended meetings of the American Society for Clinical Investigation and the Association of American Physicians.

Dr. James J. Griffitts of Miami was one of the principal speakers at a recent meeting of the New York State Medical Society. The title of his address was "Blood Exchange Clearing House Functions with Special Reference to National Reciprocity Program."

Dr. Carl M. Herbert Jr. of Gainesville has been named a Diplomate of the American Board of Obstetrics and Gynecology.

Dr. Raymond R. Sessions of Kissimmee has returned from Columbus, Ohio, where he took a postgraduate course at the University of Columbus Medical College.

Dr. James L. Anderson of Miami is scheduled to be in Berlin, Germany on August 17 where he will attend a world meeting on mental health.

Dr. Francis H. Langley of St. Petersburg, president of the Florida Medical Association, has received the honorary Doctor of Science degree from Ohio Wesleyan University from which he was graduated in 1922. The degree was conferred upon Dr. Langley at the 112th commencement exercises held in June on the campus at Delaware, Ohio.

The 42nd Annual Clinical Congress of the American College of Surgeons has been scheduled for October 8-12, 1956, in San Francisco. Headquarters for the Congress will be the Civic Auditorium, with some of the scientific sessions scheduled at the Fairmont and Mark Hopkins Hotels.

Mrs. Richard F. Stover of Miami has been elected Constitutional Secretary of the Woman's Auxiliary to the American Medical Association. The election took place during the Auxiliary's recent annual meeting in Chicago.

The 21st Annual Congress of the United States and Canadian Sections of the International College of Surgeons is being held in the Palmer House, Chicago, Sept. 9-13.

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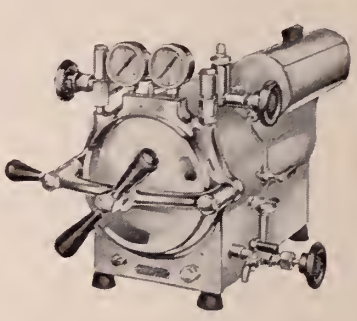

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1. Braceland, F.J.: Texas State J. Med. 51:287 (June) 1955.
2. Lemere, F.: Northwest Med. 54:1098 (Oct.) 1955.

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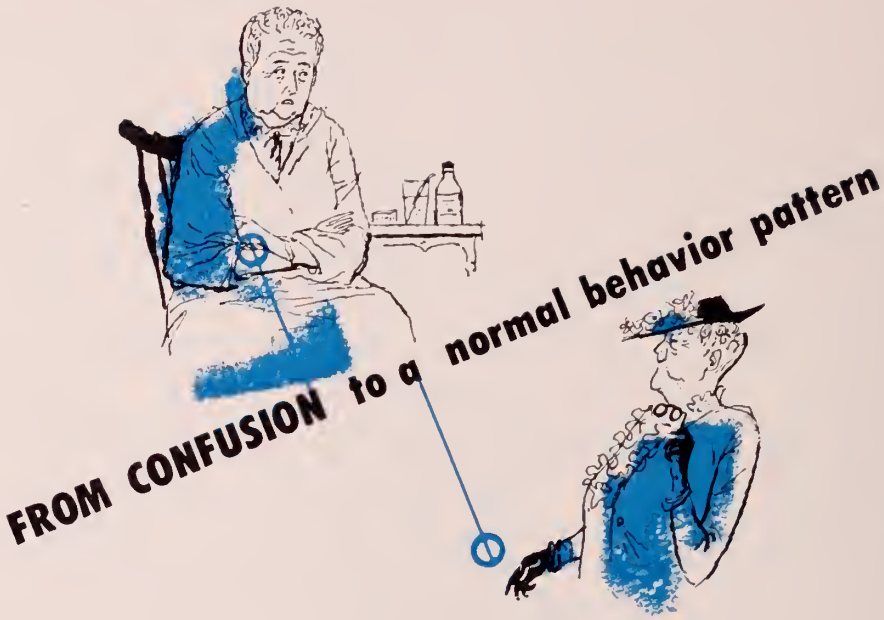

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1. *Levy, S.* J.A.M.A. *153:1260, 1953.*
2. *Thompson, Lloyd & Proctor, Rich.* N. C. State, *Dec. 54*
3. *Thompson & Proctor,* Clinical Med *April, 1956*

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OBITUARIES

Valentine Everhardt Jenkins

Dr. Valentine E. Jenkins of Miami Beach died in Beth David Hospital, New York City, on March 30, 1956, of metastatic carcinoma after an illness of a year. He was 34 years of age.

A native Floridian, Dr. Jenkins was born in Miami in 1921. He attended local schools and the University of Florida, and received his medical training at Emory University School of Medicine, where he was graduated in 1945. After completing an internship at Jackson Memorial Hospital in Miami, he served a residency at the Veterans Administration Hospital in McKinney, Texas. For several years he was on active duty as a first lieutenant with the Army Medical Corps.

In 1952 Dr. Jenkins began the practice of internal medicine and cardiology in Miami and Miami Beach, and was associated with Dr. E. Sterling Nichol. He was a member of the staff of Jackson Memorial Hospital, National Children's Cardiac Hospital and St. Francis Hospital, and was a member of the faculty of the University of Miami School of Medicine. One of the founders of the Miami Heart Institute, he worked tirelessly in its development, especially in the establishment of the rehabilitation center there. He engaged in extensive research work on the treatment of coronary artery disease with the use of anticoagulants. The last year of his life he devoted to exploration of the field of cancer therapy.

Locally Dr. Jenkins was active in numerous civic organizations and in the First Methodist Church of Miami Beach. He was a summer member of the Bath Club.

Dr. Jenkins was a member of the Dade County Medical Association and the Florida Medical Association. He also held membership in the American Medical Association and the Southern Medical Association, and was a diplomate of the American Board of Internal Medicine.

Surviving are the widow, Adeline; three sons, Valentine Everhardt Jr., Robert Harold and Thomas Edward; the parents, Mr. and Mrs. Leo Jenkins; one sister, Mrs. J. E. Liebhart, all of Miami; three brothers, Harold and Edward of Miami, and Robert, a student at Emory University School of Medicine, Atlanta; and a grandmother, Mrs. Sybil Jenkins, of Miami.

David G. Humphreys

Dr. David G. Humphreys, of Fernandina Beach, died on March 16, 1956, of a heart attack while returning from a call on an old patient in the middle of the county. Dr. Humphreys died in the fulfilment of his obligations to his profession and while attending to his duties as he found them for a period of 59 years of general practice in Nassau County.

Dr. Humphreys was born at Harrison Station, Miss., Jan. 17, 1873, the son of a Presbyterian minister. He received his premedical education in Mississippi and in Lake City in this state. He was graduated from the University of Kentucky in 1896 with the degree of M.D., and did postgraduate work in the City Hospital, Louisville, Ky., for one year. Returning to Florida, he married Miss Eva Mizall Henry in 1897 and entered general practice in Fernandina that same year.

Dr. Humphreys passed through the horse and buggy days of the general practitioner to the modern days of medicine.

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*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

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*Moyer, J. H., and others: J. Chronic Dis. 2:670, 1955.

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He was a life member of the Florida Medical Association, was for many years a member of the Duval County Medical Society and has been continuously president of the Nassau County Medical Society since its organization in 1943. He was a member of the American Medical Association and the Southern Medical Association. Locally, he was a charter member of the Fernandina Rotary Club, and a member and elder of the First Presbyterian Church for many years.

At the recent dedication of Nassau General Hospital in Fernandina Beach, he was recognized and received an award from the hospital staff and citizens of Fernandina Beach for achievement in his profession in Nassau County.

Survivors are his widow, Mrs. Eva Humphreys, Fernandina Beach; two daughters, Mrs. John R. Hardee Jr., Brownsville, Texas, and Mrs. E. C. Burgess, Fernandina Beach; a son, Mr. Henry Humphreys, Brownsville, Texas, and nine grandchildren.

William S. Nichols

Dr. William S. Nichols died at his home in Lake City on March 28, 1956, shortly after suffering an acute coronary occlusion. He was 57 years of age.

The son of the late Nicholas Richardson Nichols and Margaret Sowell Nichols, Dr. Nichols was born in Athens, Ala., in 1899. He attended elementary schools there and was graduated from the Athens High School in 1916. He then entered the University of Alabama, where he completed his premedical schooling in 1918. For his medical training he chose Vanderbilt University School of Medicine, where he was awarded the degree of Doctor of Medicine in 1922. After interning for two years at the Kansas City Hospital in Kansas City, Mo., he served for two years with the Florida State Board of Health. There followed a period of postgraduate training at the New Orleans Eye, Ear, Nose and Throat Hospital. Upon completion of this special course, he returned to Lake City in 1926 and entered the practice of his specialty of ophthalmology and otolaryngology.

Throughout the three decades that he practiced in Lake City, Dr. Nichols was prominent in social and civic affairs. He was chairman of the Board of Directors of the First National Bank and president of the Lake City Savings and Loan Association. A member of the First Methodist Church, he served for years on its board of trustees. He

(Continued on page 192)

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1. Johnston, T. G., and Cazort, A. G.: J. Allergy 27:90, 1956. 2. Schwartz, E.: New York J. Med. 56:570, 1956. 3. Schiller, I. W., et al.: J. Allergy 27:96, 1956.

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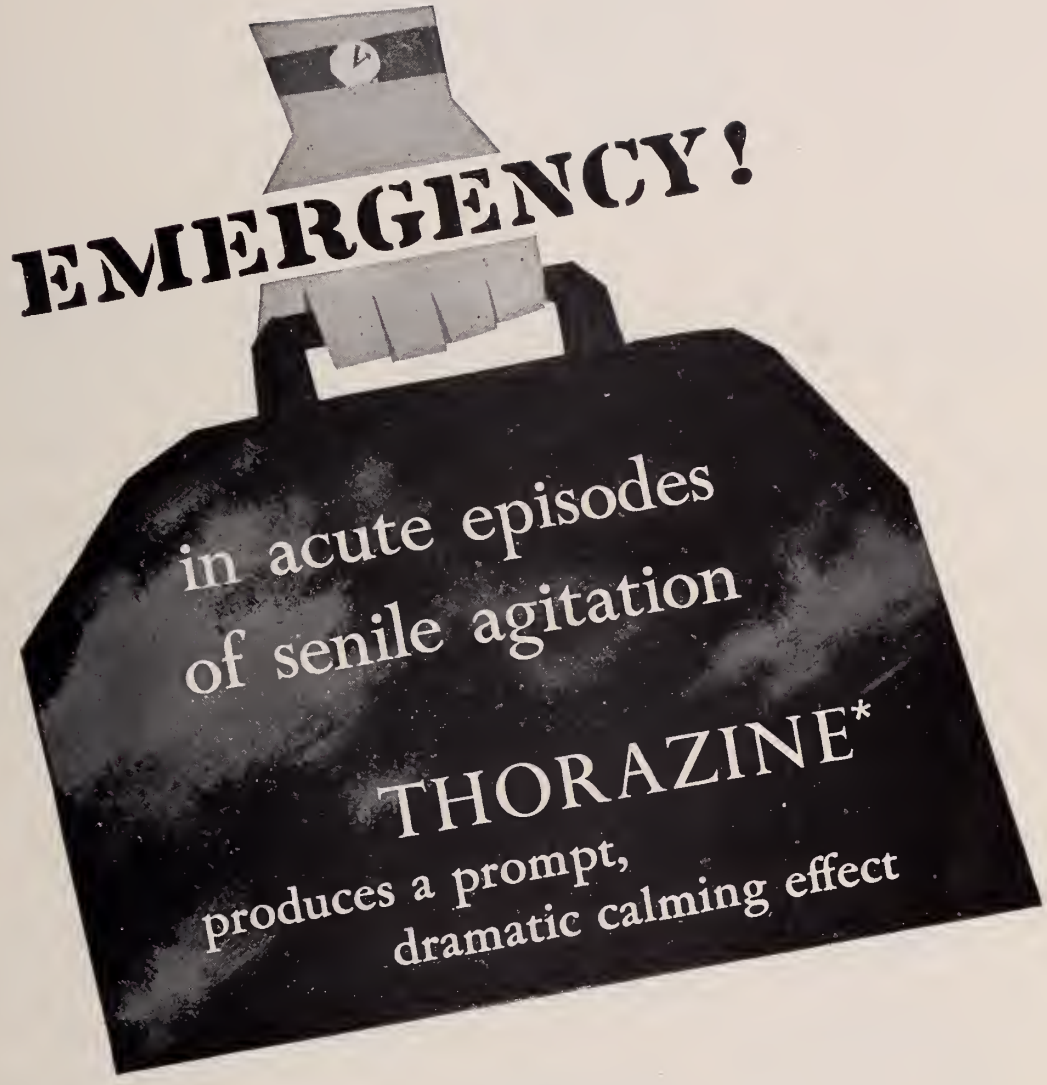

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(Continued from page 186)

was a member of the Elks Lodge and of Masonic Lodge No. 16 of Athens, Ala.

Dr. Nichols was a member of the Columbia County Medical Society and of the Florida Medical Association. He also held membership in the American Medical Association and his specialty organizations. Under Governors Cone, Holland and Caldwell he served as State Ophthalmologist.

Surviving are the widow, Mrs. Marie Haile Nichols, of Lake City; one brother, Robert C. Nichols, of Nashville, Tenn.; one sister, Mrs. W. B. Neville, of Eutaw, Ala.; three nephews, and three nieces.

Robert P. Henderson

Dr. Robert P. Henderson of Orlando died at his home on March 22, 1956, following a heart attack. He was 62 years of age.

A native of Florida, Dr. Henderson was born in Bartow on Sept. 25, 1893. Upon completion of his academic training at the University of Florida, he entered Vanderbilt University School of Medicine in 1913 and was graduated with the degree of Doctor of Medicine in 1917. That same year he entered the Navy, served during World War I and remained in service with the rank of lieutenant until 1925.

Retaining his reserve status, Dr. Henderson then entered the private practice of urology after completing postgraduate study in New York City. He located in Tampa in 1925 and continued to practice his specialty there until 1935, when he moved to Orlando. In 1941 he was recalled to duty with the Navy, serving until 1945 when he received a medical retirement with the rank of captain. He was medical officer of the carrier U.S.S. Independence when it was torpedoed by the Japanese in the Battle of Tarawa. Although injured himself, receiving numerous fractures of the bones of his feet and one wrist, he remained on duty for days caring for the many injured. Partial recovery took place after months of hospitalization. He received the Silver Star for distinguished service.

Upon his return to Orlando, Dr. Henderson was active in medical circles. In 1949 and 1950 he was chief of staff at Orange Memorial Hospital. Locally, he was a member of the American Legion and also held membership in the Presbyterian Church.

In 1949 Dr. Henderson served as president of the Orange County Medical Society. He was for

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30 years a member of the Florida Medical Association and also was a member of the American Medical Association, the Southern Medical Association, the Southeastern Surgical Association and the Southeastern Section of the American Urological Association.

Surviving are two sons, Robert P. Henderson III, of Orlando, and Richard M. Henderson, a student at Florida Southern College in Lakeland; his mother, Mrs. Ellen Hayes Henderson, of Tampa; and one granddaughter.

Charles William Bartlett

Dr. Charles William Bartlett of Tampa died at St. Joseph's Hospital in that city on March 1, 1956, following a heart attack suffered a few days earlier. He was 56 years of age.

The son of the late Dr. and Mrs. C. W. Bartlett of Tampa, Dr. Bartlett was born in Havana, Cuba, while his father was with the American Army of Occupation as a medical lieutenant. He attended school in Tampa and had his academic training at the University of Florida, where he became a member of Theta Chi fraternity. Later he attended the University of Maryland and received the degree of Doctor of Medicine from the University of Tennessee College of Medicine in 1924. He then served an internship at Memphis General Hospital and engaged in postgraduate study in pediatrics at John Gaston Hospital in Memphis. His medical fraternity was Chi Zeta Chi.

In February 1925, Dr. Bartlett returned to Tampa to enter the practice of pediatrics and continued to practice his specialty there for more than 30 years. A veteran of World War I, he was active locally in civic affairs. He was a member of the American Legion, the Benevolent and Protective Order of Elks, and the Tampa Yacht and Country Club. He also was a member of Christ the King Catholic Church.

A particularly active member of local medical groups, Dr. Bartlett was City Health Officer from 1929 to 1930, filling the vacancy left by the death of his father, and he was County Health Officer from 1933 to 1934. He was instrumental in furthering the Blood Bank organization. In 1952, Governor Warren appointed him to the State Board of Medical Examiners. A former president of the Hillsborough County Medical Association, he was also a member of the Florida Medical Association, the American Medical Association,

(Continued on page 200)

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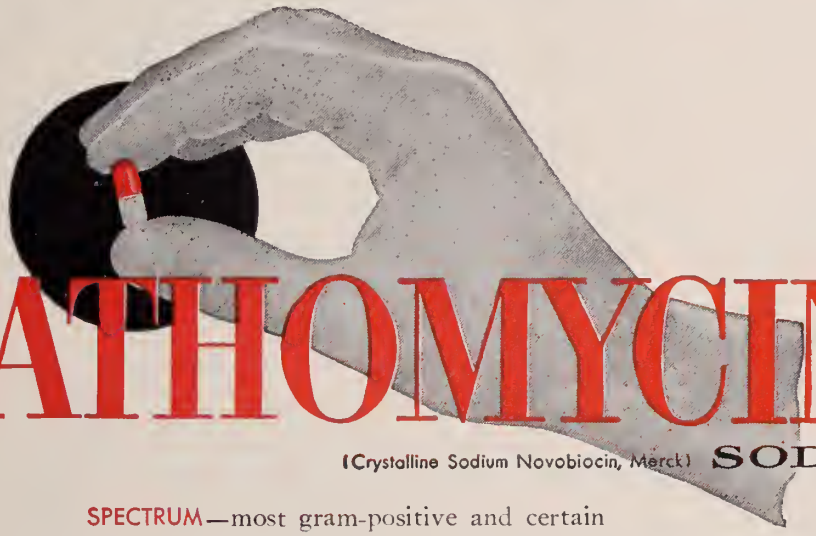

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(Continued from page 194)

the Southern Medical Association, the Florida Pediatric Society and other organizations of his specialty.

Surviving are the widow, Mrs. Ruby McLain Stafford Bartlett; two daughters, Mrs. James F. Baughman and Mrs. Richard L. Miller; a grandson, William Bartlett Baughman; three sisters, Mrs. Ernest Gudath, Mrs. Arthur Velasco and Mrs. Frank Wilder, and a brother, Dr. W. A. Bartlett, all of Tampa, and several nieces and nephews. Another daughter, Charlotte Bartlett, died in February 1955.

George Milner Mitchell

Dr. George Milner Mitchell of Jacksonville died in a local hospital on March 30, 1956, following an attack of coronary thrombosis. He was 72 years of age.

Born in Zebulon, Ga., in 1883, Dr. Mitchell received his education in his native state. For his medical training he attended the Atlanta College of Physicians and Surgeons, now Emory University School of Medicine, and was awarded the degree of Doctor of Medicine in 1906.

After practicing medicine for one year at Tifton, Ga., he moved to Barnesville, Ga., in 1907. He practiced there for four years before locating in Jacksonville in 1911, where he engaged in the general practice of medicine for 45 years. During World War I, Dr. Mitchell served as a captain in the Medical Corps of the Army in the First Evacuation Hospital Unit and with the Army of Occupation. Locally, he was a member of the Church of the Good Shepherd and a life member of the Timuquana Country Club. He was also a Mason.

A member of the Duval County Medical Society, Dr. Mitchell was a life member of the Florida Medical Association, having held membership for 44 years. He also was affiliated with the American Medical Association and the Southern Medical Association.

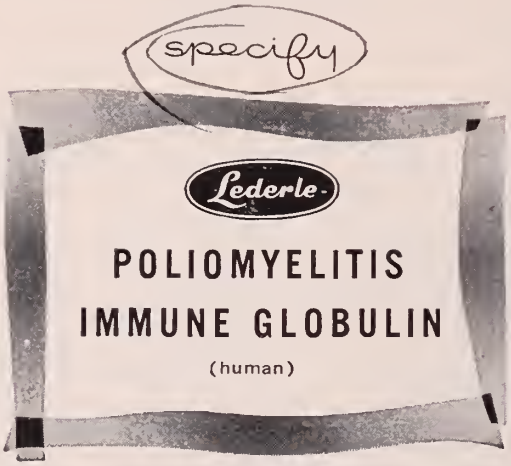
In 1906, Dr. Mitchell was married to Blanche Del Pino of Key West, who survives him. Also surviving are one daughter, Mrs. Cornelia Mitchell Graves, of St. Augustine; and two sisters, Miss Mamie Mitchell and Mrs. John T. Middlebrooks, both of Barnesville, Ga.

William M. Davis

Dr. William M. Davis of St. Petersburg died in a local hospital on Feb. 8, 1956, of a heart ailment which had forced his almost complete retirement more than two years ago. He was 78 years of age.

A native of Ohio, Dr. Davis was born in Dayton on Feb. 25, 1877. At an early age he was taken by his family to Pittsburgh, Pa., and attended public schools there. He received his academic training at Washington and Jefferson College, where he was graduated in 1899, and was awarded the degree of Doctor of Medicine by the Jefferson Medical College of Philadelphia in 1902. After completing an internship in Pittsburgh, he entered the private practice of medicine in that city.

In the winter of 1906 he visited St. Petersburg because of ill health. The next year, suffering from severe glomerular nephritis, he returned to become a permanent resident and to practice medicine there for nearly half a century. Covering the sandy roads and trails by bicycle in the early days, he saw the town of 1,800 grow into today's important city. He was the first city physician and held that post for several years. He set up the first city bureau of vital statistics, instituted



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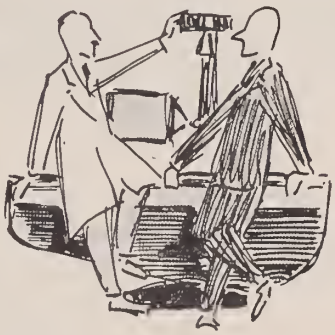

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many of the vital statistics records of Pinellas County, and was a pioneer in vital statistics in the state. It was in 1911 while he was city physician that he began keeping St. Petersburg's vital statistics as a volunteer service, and he continued the task in his office on a seven day, round-the-clock basis with the assistance of a deputy until the records were taken over in 1948 by the County Health Department.

Dr. Davis was a factor in almost all of the developments that have come in medical, surgical and general health services in St. Petersburg and Pinellas County. He was instrumental in the establishment of the original city hospital, now Mound Park Hospital, which he later served as chief of staff, and he was on the staff at St. Anthony's Hospital and Mercy Hospital. A charter member and past president of the Rotary Club, he also was a charter member of the St. Petersburg Yacht Club and the Quarterback Club. Always active across the years in civic projects, he was likewise active in church work. He was one of the founders of the First Presbyterian Church, a former elder and former clerk of the session. For many years he served as superintendent of the Sunday School and once wrote a history of the church. He was elected president of the Florida Jefferson Medical College Alumni, and his social fraternity was Phi Gamma Delta.

A charter member of the Pinellas County Medical Society, Dr. Davis was its first secretary-treasurer, an office which he held for seven years. He then served as its seventh president. A member of the Florida Medical Association since 1916, he served on its Board of Governors at one time. He also held membership in the American Medical Association and other medical organizations.

Dr. Davis is survived by his widow, Mrs. Lucy Stoner Davis; two sons, Thomas D. and Lyon Logan Davis; four grandchildren, Lyon Logan II, Nancy, William and David Davis; and one sister, Mrs. Margaret Taylor, all of St. Petersburg.

The Public Relations Committee and the Medical Economics Committee must work closely together. In fact, the latter may be considered more of a study group whose conclusions can be presented by the former.

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1. Klohs, M.W.; Draper, M.D., and Keller, F.: Alkaloids of Rauwolfia Serpentina Benth. III. Rescinnamine, a New Hypotensive and Sedative Principle, J. Am. Chem. Soc. 76:2843 (1954).
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Floridians Glad to Return to Florida to Cool Off

Prior to the annual meeting of the Woman's Auxiliary to the American Medical Association in Chicago, June 11-15, I think that all of us from Florida attending were looking forward to going —the idea of putting on our bonnets, wearing gloves, being dressed up and in the cool Lake Michigan breezes seemed to appeal to all of us, but the best laid plans of mice, men and Floridians didn't turn out. A middle west heat wave was on and all who had anticipated the cool breezes and nice weather came home so very, very happy to be in Florida and from Florida where one has a chance to keep cool or get cool once in awhile.

The annual meeting, held at the Conrad Hilton, the largest hotel I was informed in the United States, having over 3000 rooms, had air conditioned meeting rooms but the heat outside hovering from 95 to 100 degrees day and night offset much of the advantages of the air conditioned rooms. Hotel rooms had no air conditioning and fans weren't available at the hotel — so we sweltered, went without sleep, looked bleary-eyed all day and sat through the long meetings in our bonnets and gloves, wishing we were back home where we could be cool and comfortable.

If it had not been for the bright spots and part of the program, many of us would have been off meetings from now on because of the physical discomfort of a city the size of Chicago in the midst of a heat wave. There were some good meetings, good speakers and nice luncheons that helped to make up for the physical misery of Chicago in June.

Mrs. Mason G. Lawson, who proved so popular when visiting Florida as a representative of the national auxiliary in 1952 and again when she came as president of the AMA Auxiliary in May, presided with dispatch and diplomacy throughout the meeting and probably will go down in history of the national auxiliary as one of our most charming and certainly one of our most democratic presidents. The reports were interesting, even though as reports are bound to be, there was some repetition. Mrs. Scottie J. Wilson, president of the Woman's Auxiliary to the Florida Medical Association, gave the last year's report for the Florida auxiliary, reporting

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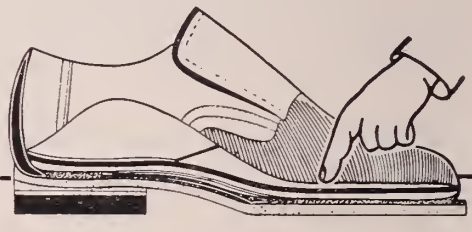

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that again Florida had gone over 100 per cent in subscriptions for Todays Health, had practically doubled both the number of Future Nurses Clubs we had and the number of students who were members; had reached our $1.00 per member in the American Medical Education Foundation and had done our share of participation in all auxiliary programs and projects. State presidents are given two minutes to report on the work of their auxiliaries and those of us from the South have a genuine objection to this, for our presidents talk slower than those in other parts of the country and consequently the bell is frequently sounded on all the southern state presidents before they can finish. The delegation from Florida was proud, however, of our report which reflected the fine work of Mrs. Samuel S. Lombardo and her officers and chairmen from last year. On Thursday morning, June 14, the following officers were elected for the 1956-57 year for the Woman's Auxiliary to the American Medical Association: Mrs. Robert Flanders, New Hampshire, President; Mrs. Paul C. Craig, Pennsylvania, President-elect; Mrs. E. Arthur Underwood, Washington, First Vice President; Mrs. Clark Bailey, Kentucky, Second Vice President; Mrs. Frank Gastineau, Indiana, Third Vice President; Mrs. Edgar E. Quayle, Washington, D. C., Fourth Vice President; Mrs. Carl Burkland, California, Fifth Vice President; Mrs. M. A. Gold, Montana, Treasurer, Mrs. Richard F. Stover, Florida, Constitutional Secretary. Directors for one year: Mrs. Ross P. Daniels, West Virginia; Mrs. Harlan English, Illinois; Mrs. William Mackersie, Michigan and Mrs. Mason G. Lawson, the Immediate Past President. Directors for two years: Mrs. George A. Garrison, Oklahoma; Mrs. C. R. Pearson, Wisconsin and Mrs. W. G. Thuss, Alabama.

Florida answered the roll call with 13 delegates and her presidential delegate present which was not quite our 100 per cent, but near to it. The resolutions from Florida pertaining to standing rules for the nominating committee and changes in number of House of Delegates were referred to committees who were charged by the House of Delegates with coming to the 1957 annual meeting with concrete recommendations for standing rules for the nominating committee and with concrete recommendations for change in the make up of the House of Delegates. We might add that the most enthusiastic and most democratic discussion we have seen on the floor of the

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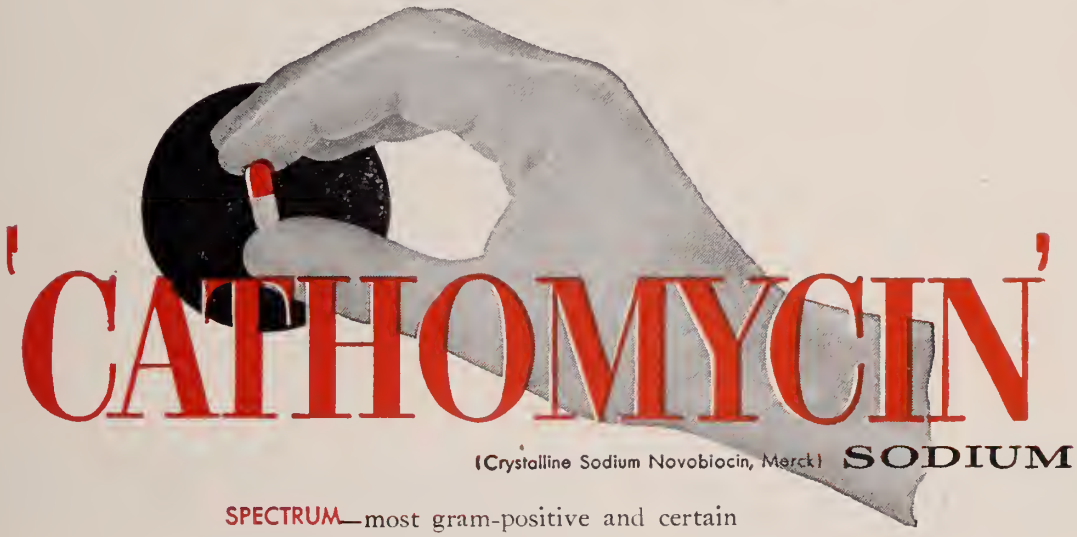

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House of Delegates resulted from these two resolutions.

Yes, the meeting was good, the workshops outstanding but all from Florida were glad to get back to Florida where we could cool off and take it easy. A trip to Chicago during a heat wave can make anyone happy they live in Florida — don't try it — just take our word for it.

Mrs. Richard F. Stover.

BOOKS RECEIVED

Handbook of Pediatrics. By Henry K. Silver, M.D., C. Henry Kempe, M.D., and Henry B. Bruyn, M.D. Pp. 550. Price $3.00. Los Altos, Calif., Lange Medical Publications, 1955.

The practicing physician and the medical student will find in this Handbook a concise and readily available digest of the material necessary for the diagnosis and management of pediatric disorders. Emphasis is placed on the clinical aspects of the subject covered, but summaries of physiologic principles are included wherever necessary. This little volume, concise in format, is intended to supplement rather than to replace the more complete pediatric texts and reference works. Established concepts of pediatric diagnosis and treatment are in all cases given preference over the theoretic or experimental; however, recent advances are included wherever the authors deemed their inclusion suitable in a handbook of this type.

Dr. Silver is Associate Professor of Pediatrics, Yale University School of Medicine, New Haven, Conn.; Dr. Kempe is Assistant Professor of Pediatrics, University of California School of Medicine, San Francisco; and Dr. Bruyn is Assistant Professor of Pediatrics and Medicine, University of California School of Medicine, and Assistant Clinical Professor of Pediatrics, Stanford University Medical School, San Francisco.

Peptic Ulcer. By Clifford J. Barborka, M.D., and E. Clinton Texter Jr., M.D. Pp. 290. Price, $7.00. Boston, Little, Brown and Company, 1955.

This concise, practical handbook, dedicated to the general practitioner, correlates the rapid advances in the therapy of peptic ulcer that have developed in the last half dozen years. Diagnostic methods of proved value are discussed along with the newer concepts of treatment. The value and limitations of both medical and surgical treatment are appraised and analyzed.

There is particular emphasis on the patient-physician relation. The new concepts of the mechanism of ulcer pains, including the role of the acid factor, the motor factors and the vascular factors, are presented. Considerable attention is given to the surgical aspects of treatment, including the frequency of and indications for surgery, along with an impartial evaluation of the several operations which have been proposed recently, including vagotomy, gastric resection, pyloroplasty, and combinations of these procedures.

Postsurgical management is discussed, and a practical program is presented for the management of the patient with ulcer complications. Particular attention is devoted to the anticholinergic drugs which have not been discussed heretofore, in relation to their pharmacology, their value in the acute attack, and their place in the management of the long term ulcer problem. The appendix, with its recipes for foods commonly used in peptic ulcer management, and sample menus, will be found useful.

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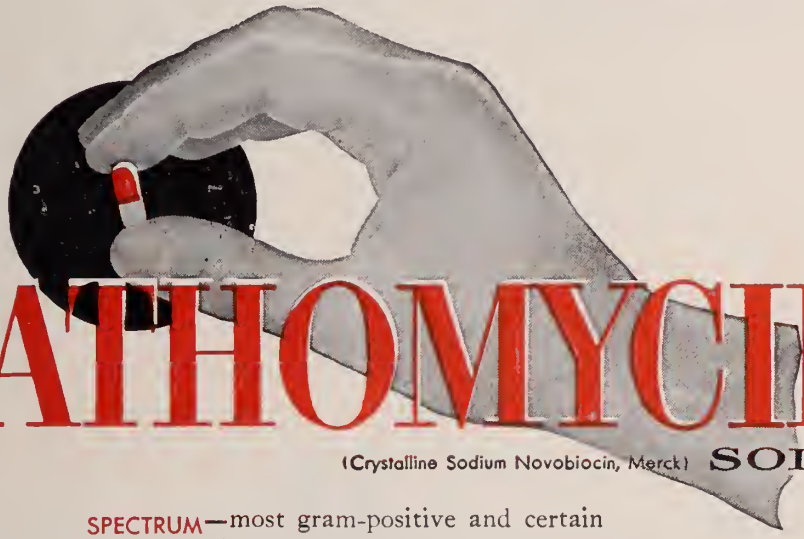

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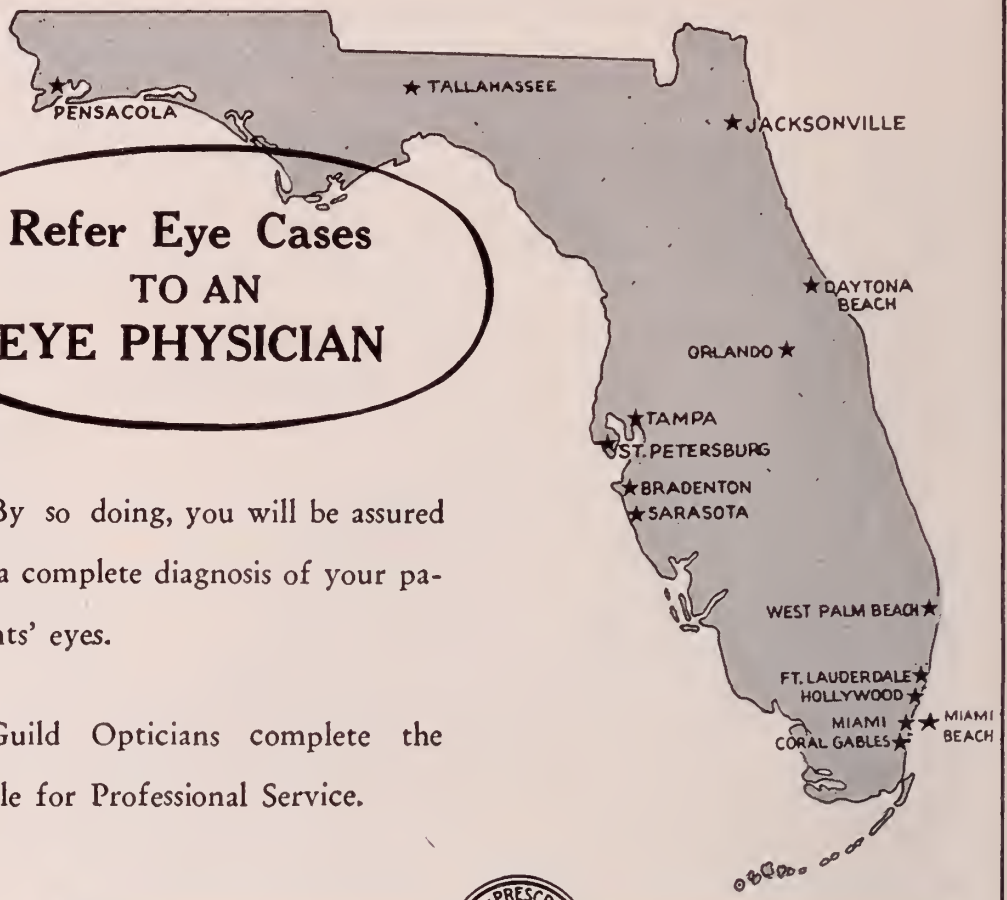

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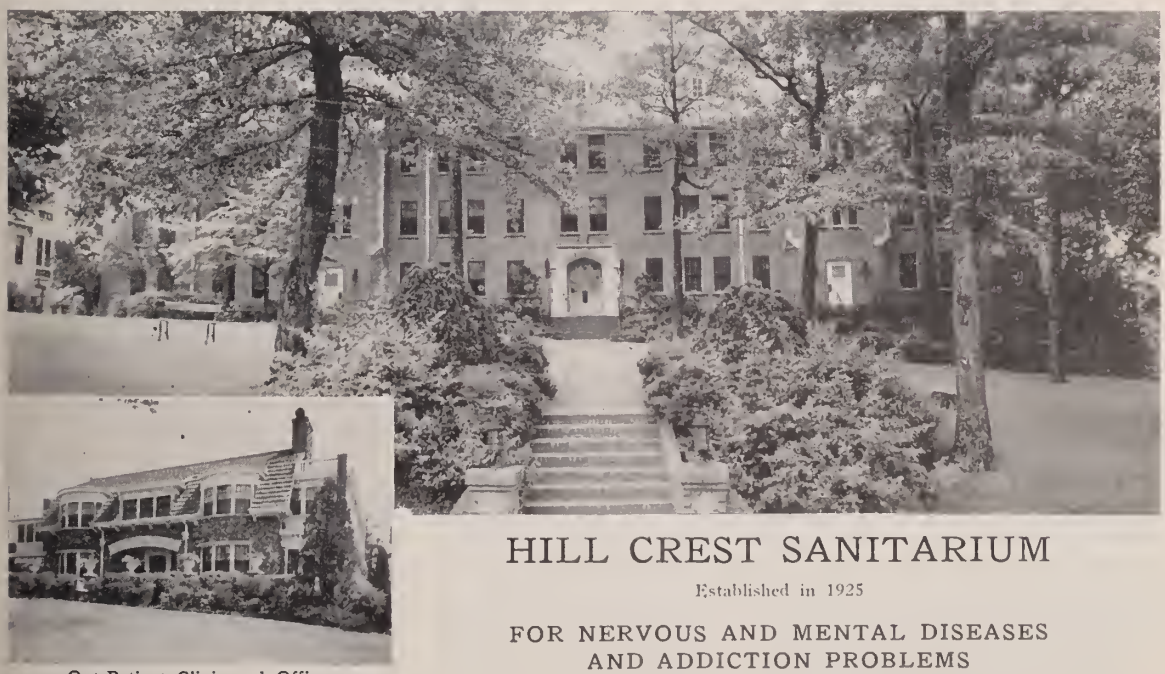

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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Albert G. Love IV, Gainesville	G. Leonard Emmel, Gainesville	2nd Tues.	57
**Bradford, Gilchrist, Union*				
Bay	Joseph H. Morris, Panama City	John J. Hollomon Jr., Panama City	1st Tues.	29
Brevard	Isabel Roberts, Melbourne	Jack T. Bechtel, Eau Gallie	2nd Tues.	42
Broward	Thomas F. Huey Jr., Fort Lauderdale	Anthony C. Galluccio, Hollywood	4th Tues.	141
Columbia	Thomas H. Bates, Lake City	Clifton G. York, Lake City	1st Mon.	11
**Baker*				
Dade	Hunter B. Rogers, Miami	Vincent P. Corso, Miami	1st Tues.	764
DeSoto-Hardee-Highlands-Glades	Merle C. Kayton, Wauchula	Roland W. Banks, Wauchula	1st Tues.	27
Duval	Joseph J. Lowenthal, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	318
**Clay*				
Escambia	Gretchen V. Squires, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	104
**Santa Rosa*				
Franklin-Gulf	Harold B. Canning, Wewahitchka	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	James N. Patterson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	203
Indian River	Vernon L. Fromang, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	10
Jackson-Calhoun	Richard H. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	18
Lake	Geoffrey H. Binneveld, Leesburg	J. Basil Hall, Tavares	1st Wed.	34
**Sumter*				
Lee-Charlotte-Collier-Hendry	Joseph L. Selden Jr., Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	42
Leon-Gadsden-Liberty-Wakulla-Jefferson	Robert H. Mickler, Tallahassee	Odis G. Kendrick Jr., Tallahassee	Quarterly	71
Madison	Candler K. Hayes, Madison	Wilmer J. Coggins, Madison		8
Manatee	Richard V. Meaney, Bradenton	Eugene E. Biel, Bradenton	2nd Tues.	29
Marion	William J. McGovern, Ocala	Robert L. Gibson, Ocala	3rd Tues.	32
**Levy*				
Monroe	Allen Shepard, Key West	William R. Ploss, Key West	1st Thurs.	14
Nassau			Last Fri.	9
Orange	Thomas C. Butt, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	200
**Osceola*				
Palm Beach	Walter R. Newbern, West Palm Beach	Horace D. Atkinson, West Palm Beach	4th Mon.	151
Pasco-Hernando-Citrus	Gail M. Osterhout, Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Daniel F. H. Murphey, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	250
Polk	James T. Shelden, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	111
Putnam	Bennie J. Massey, Palatka	Bernard E. Kane, Crescent City	2nd Tues.	10
St. Johns	Reuben J. Plant Jr., St. Augustine	Roy E. Campbell, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Alfred J. Cornille, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	26
Sarasota	Eugene D. Liddy Jr., Sarasota	Karl R. Rolls, Sarasota	2nd Tues.	64
Seminole	William V. Roberts, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	Shirley L. Hadden, Live Oak	Hiram B. Curry, Jasper	1st. Sat.	12
**Hamilton, Lafayette*				
Taylor	Ralph J. Greene, Perry	John H. Parker Jr., Perry	Last Fri.	5
**Dixie*				
Volusia	Theodore F. Hahn Jr., DeLand	Achille A. Monaco, Daytona Beach	2nd Tues.	88
**Flagler*				
Walton-Okaloosa	Henry C. White Jr., Fort Walton Bch.	George W. Barrow Jr., Crestview	3rd Tues.	21
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The First Decade of Atomic Medicine
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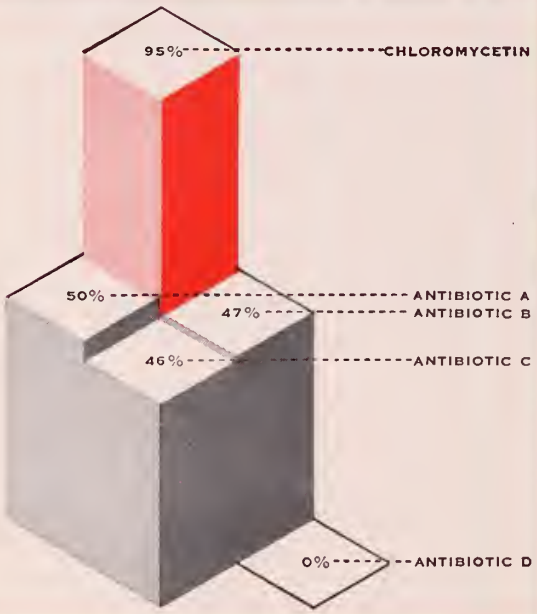
SENSITIVITY OF COMMON PATHOGENS TO CHLOROMYCETIN AND FOUR OTHER MAJOR ANTIBIOTIC AGENTS



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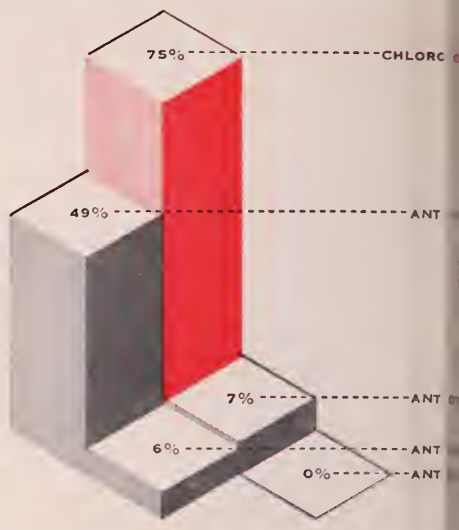
(148-227 STRAINS)



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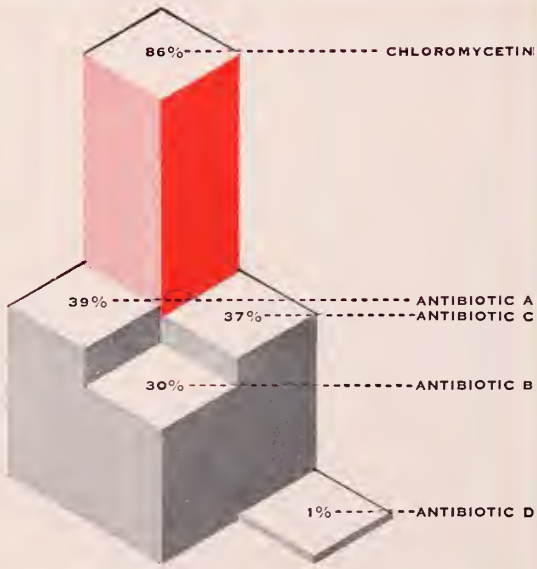

PSEUDOMONAS AERUGINOSA
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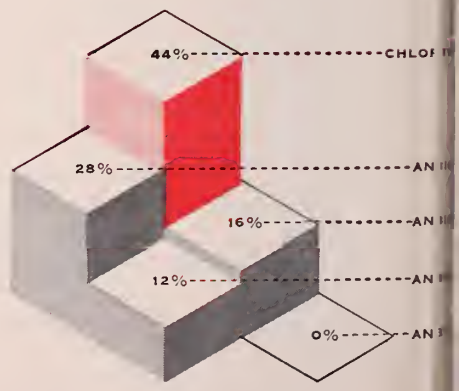

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References: (1) Felix, N. S.: *Pediat. Clin. North America* 3:317, 1956. (2) Joron, G. E.; Fowler, A. F.; de Vries, J.; Reid, G., & Mathews, W. H.: *Canad. M. A. J.* 73:956, 1955. (3) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (4) Perry, R. E., Jr.: *North Carolina M. J.* 16:567, 1955. (5) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (6) Murphy, F. D., & Waisbren, B. A., in Murphy, F. D.: Medical Emergencies: Diagnosis and Treatment, ed. 5, Philadelphia, F. A. Davis Company, 1955, p. 557. (7) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305, 1955. (8) Horton, B. F., & Knight, V.: *J. Tennessee M. A.* 48:367, 1955.

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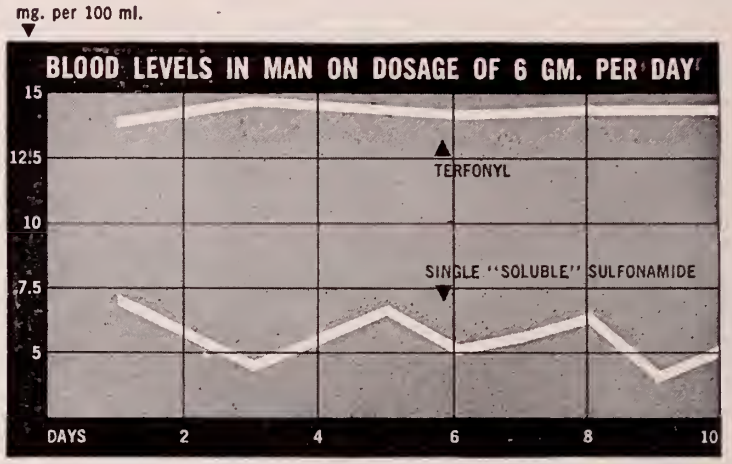

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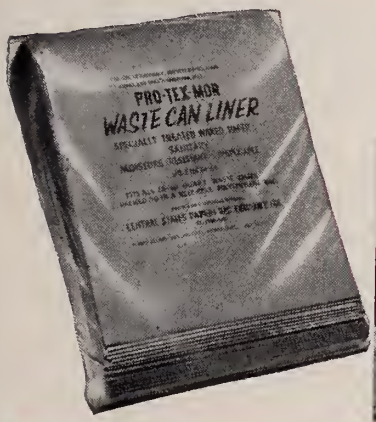

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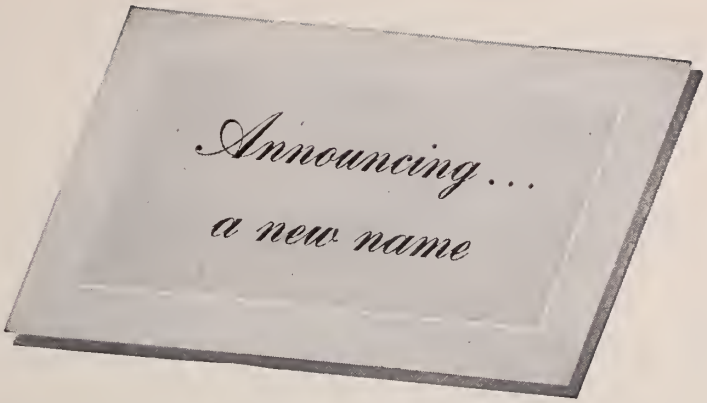

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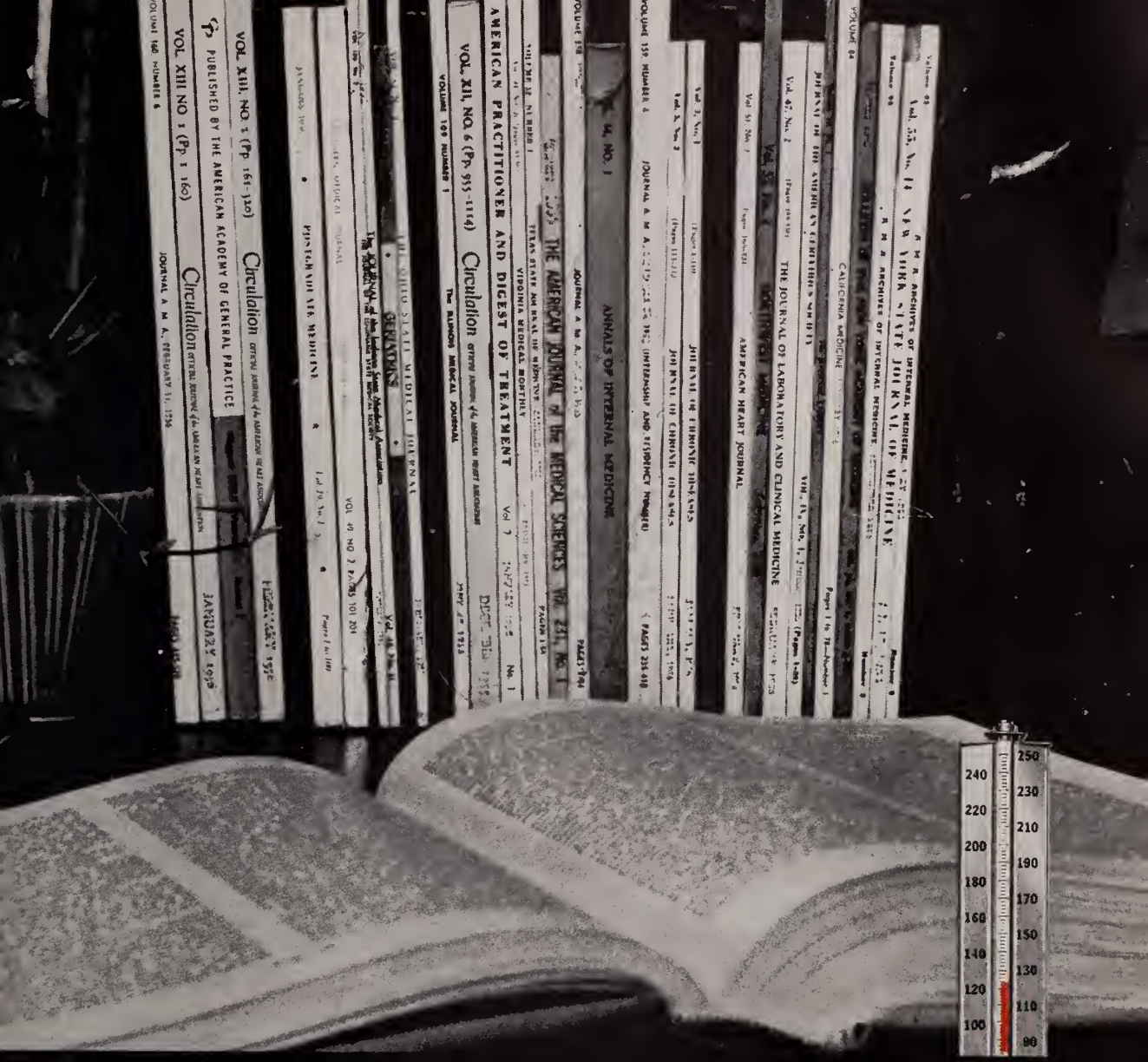

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1. Moser, M.: New York State J. Med. 55:1999 (July 15) 1955. 2. Agrest, A., and Hoobler, S.W.: J.A.M.A. 157:999 (March 19) 1955. 3. Smirk, F.H.: Am. J. Med. 17:839 (Dec.) 1954. 4. Smirk, F.H., and McQueen, E.G.: J. Chron. Dis. 1:516 (May) 1955. 5. Waldman, S., and Pelner, L.: Am. J. M. Sc. 231:140 (Feb.) 1956.

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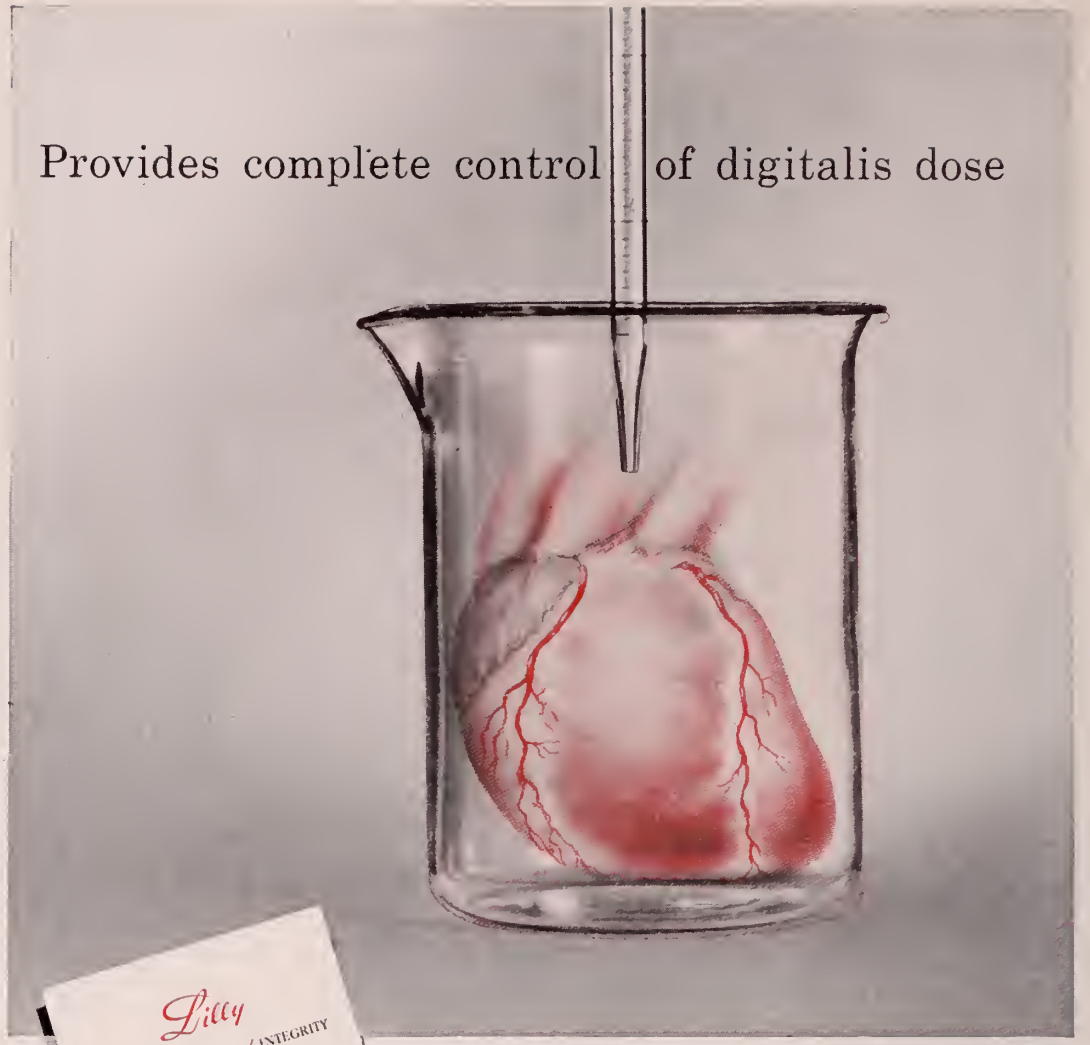

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Research Plan For Florida's Permanently And Totally Disabled Indigents

Analysis of 1,429 Cases

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At the beginning of this century, the physician was a valuable aid in the planning and conduct of the civic affairs of the community in which he lived. He was a part of its social welfare activities and cognizant of their varied functions, but did not identify them as social welfare in the accepted sense of the term today. He was either a member of the local legislative and governing body, or his advice was frequently sought. Two factors have materially altered this enviable position. First, the physician became more the scientist. Consistent with the phenomenal general scientific advances of the last 50 years, medical colleges have placed emphasis on the science of medicine and lessened the teaching of the art of medicine and its adaptation in practice. He therefore had less and less contact with and influence on the civic activities of town and country, this change contributing in part, no doubt, to the alteration in the relation to his fellow citizens.

The second factor was the beginning and subsequent rapid development of a new profession—that of the social welfare worker. Twenty years ago, the two, the physician and the social worker, looked askance at each other. Today, the medical profession recognizes that their objectives are similar, namely, to help the needy person. The physician realizes that his patient must be properly fed, must have reasonable comfort and must in some instances have long periods of rest with a degree of security. In the case of the indigent, he has come to expect the social welfare services to see that these needs are provided. The social worker is beginning to realize that the physician's assistance in welfare work is of more value than filling out a form.

Physicians are an integral part of the teams whose mission it is to provide for the needy, to prevent them as far as possible from reaching the state of permanent and total disability, and to aid them in attaining a physical and mental state that will help in restoring self respect and economic independence. Whether one cares to admit it or not, much less say it aloud, the indigent person has already lost much of his freedom of choice; hence, so far as he is concerned, he lives in a socialistic state. Every person, therefore, who by the aid of the physician and social worker is brought to, or restored to, a mental and economic status where neither the physician nor the social worker is needed, is restored to normal freedom in a democratic state.

Analysis of 1,429 Cases

The program of Aid to the Permanently and Totally Disabled was begun by the State of Florida, Department of Public Welfare, on July 1, 1955. In the nine month period since that time, up to and including the month of March 1956, 8,821 applications were received in the section for Aid to the Permanently and Totally Disabled of the division of Public Assistance. During this period 4,462 applications, or 51 per cent of the total, were disposed of; 1,668, or 37 per cent, of this number were approved while 2,794, or 63 per cent, were rejected. There remained 4,359 applications awaiting investigation and determination of eligibility. Of the 1,668 applicants declared eligible by the examining teams, 1,429 had been placed on the payroll prior to March 31 of this year. It is this 1,429 that are analyzed here (tables 1-11). The law of problem and chance is applicable only to table 1 inasmuch as there is not a sufficient number in any subdivision up to this time for statistical prediction. It should

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Medical Consultant, State of Florida, Department of Public Welfare.

Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami Beach, May 14, 1956.

be borne in mind when an analysis of percentage in relation to race is made that the present Negro population of Florida is approximately 20 per cent.

Table 1 shows the breakdown into various categories. Particular attention is directed to the fact that of the 15 disease subdivisions, four account for 1,155, or 81 per cent, of the accepted applicants. Category I, that of Infective and Parasitic Diseases, should certainly come under the preventive phase; however, since the persons in this group did reach the stage of permanent and total disability, they deserve serious consideration. Categories V and VI, namely, Mental, Psychoneurotic, and Personality Disorders and Diseases of the Nervous System and Sense Organs, account for 640, or almost half, of the total number of cases. Certainly they should be carefully analyzed.

Table 2 shows a partial breakdown under category VII, table 1, Diseases of the Circulatory System. As would be expected, arteriosclerotic heart disease with 29 cases represents the highest percentage of the total in this disease subdivision. Past experience would lead one to anticipate that the incidence of males would be practically double that of females, as is true here. While the white exceeds the Negro, nevertheless, percentagewise, the number of Negroes is larger than that of the whites.

The subdivision of Chronic Rheumatic Heart Disease represents a group which doubtless can be gradually entirely eliminated. Much research has been and is being done in this connection.

Hypertensive Diseases is the subdivision in this table showing the largest number, and contrary to previous thinking, the highest number as well as the much higher percentage is found in the Negro. Recently published studies on hypertension and coronary disease in the colored races of Africa are revealing, if not conclusive.[1]

Included in the subdivision, Other Diseases of the Heart, are unclassified cardiac diseases, almost all of which are either unspecified heart diseases or congestive failure, which is a symptom of a previously existing cardiac condition.

Table 1.—Characteristics of Cases Approved for Aid to the Disabled

July 1955 - March 1956

PRIMARY DISABLING CONDITION — BY RACE AND BY SEX

	Total	Race		Sex	
		White	Negro	Male	Female
I Infective and Parasitic Diseases	95	53	42	64	31
II Cancers, Tumor, and Other Neoplasms	39	27	12	23	16
III Allergic, Endocrine System, Metabolic, and Nutritional Diseases	41	32	9	23	18
IV Diseases of the Blood and Blood-forming Organs	3	—	3	2	1
V Mental, Psychoneurotic, and Personality Disorders	223	154	69	107	116
VI Diseases of the Nervous System and Sense Organs	417	249	168	252	165
VII Diseases of the Circulatory System	305	159	146	182	123
VIII Diseases of the Respiratory System	21	18	3	19	2
IX Diseases of the Digestive System	8	7	1	6	2
X Diseases of the Genitourinary System	6	3	3	4	2
XI Diseases of the Skin and Cellular Tissue	3	2	1	2	1
XII Diseases of the Bones and Organs of Movement	210	131	79	120	90
XIII Congenital Malformations	18	13	5	11	7
XIV Symptoms, Senility, and Ill-defined Conditions	7	2	5	3	4
XV Fractures, Amputations, and Other Disabling Conditions	33	24	9	21	12
TOTAL	1,429	874	555	839	590
Per Cent of Total	100	61	39	59	41

There is no field of medicine in relation to this program where research is more badly needed than this one. This phase will be discussed later.

Table 3 covers Mental, Psychoneurotic, and Personality Disorders. In the subdivision of Psychoses there were only 30 accepted applicants, relatively evenly distributed. Psychoneurotic disorders, of which there were only seven, are not presented for study here. Disorders of Character, Behavior, and Intelligence represents the group having the largest number in the subdivisions of this table. Idiots, imbeciles and morons constitute most of these unfortunates. There was only one diagnosis of pathologically inadequate personality. I am sure it will be understood that many persons of this type made application for public assistance, and they constitute a serious problem. If they were not permanently and totally disabled, they were rejected. Inadequate personality, however, in many cases was a contributing factor in the acceptance of applicants. It is to be hoped that the time is not far distant when in the larger

Table 2.—Diseases of the Circulatory System

Detailed Analysis — by Race and Sex

	Total	Race		Sex	
		White	Negro	Male	Female
RHEUMATIC FEVER	3	2	1	3	—
Rheumatic Fever with Heart Involvement	3	2	1	3	—
CHRONIC RHEUMATIC HEART DISEASE	16	8	8	10	6
Diseases of Mitral Valve	6	2	4	2	4
Diseases of Aortic Valve Specified as Rheumatic	2	—	2	1	1
Other Endocarditis Specified as Rheumatic	2	—	2	1	1
Other Heart Diseases Specified as Rheumatic	6	6	—	6	—
ARTERIOSCLEROTIC AND DEGENERATIVE HEART DISEASE	64	42	22	41	23
Arteriosclerotic Heart Disease	29	15	14	18	11
Arteriosclerotic Heart Disease Specified as Involving Coronary Arteries	16	12	4	11	5
Angina Pectoris Without Mention of Coronoary Disease	8	8	—	5	3
Chronic Endocarditis Not Specified as Rheumatic					
of Aortic Valve	2	—	2	2	—
of Pulmonary Valve	1	1	—	1	—
Other Myocardial Degeneration					
Fatty Degeneration	2	2	—	2	—
with Arteriosclerosis	1	1	—	—	1
Other	5	3	2	2	3
OTHER DISEASES OF HEART	36	18	18	27	9
Acute and Subacute Endocarditis	1	—	1	1	—
Functional Disease of the Heart	4	4	—	2	2
Other and Unspecified Diseases of the Heart					
Congestive Heart Failure	16	6	10	13	3
Other and Unspecified Diseases	15	8	7	11	4
HYPERTENSIVE DISEASES	155	68	87	82	73
Essential Benign Hypertension With Heart Disease	10	2	8	3	7
Hypertensive Heart Disease with Arteriolar Nephrosclerosis	9	4	5	6	3
Other and Unspecified Hypertensive Heart Disease	96	46	50	53	43
Essential Benign Hypertension Without Mention of Heart	6	1	5	4	2
Other Hypertensive Disease Without Mention of Heart	34	15	19	16	18
DISEASES OF ARTERIES	24	16	8	17	7
General Arteriosclerosis	18	12	6	11	7
Peripheral Vascular Disease, Thromboangiitis Obliterans	4	4	—	4	—
Other Diseases of Arteries	2	—	2	2	—
DISEASES OF VEINS AND OTHER DISEASES OF CIRCULATORY SYSTEM	7	5	2	4	3
Varicose Veins of Lower Extremities	5	3	2	2	3
Varicose Veins of Other Sites	1	1	—	1	—
Phlebitis and Thrombophlebitis	1	1	—	1	—
TOTAL	305	159	146	184	121

Table 3.—Mental, Psychoneurotic, and Personality Disorders

Detailed Analysis — by Race and Sex

	Total	Race		Sex	
		White	Negro	Male	Female
PSYCHOSES	30	19	11	16	14
Schizophrenic Disorders					
Simple Type	6	4	2	4	2
Catatonic	2	1	1	2	—
Paranoid	2	2	—	1	1
Schizo-affective Psychosis	1	—	1	1	—
Other and Unspecified	5	3	2	2	3
Manic-depressive Reaction	2	1	1	1	1
Paranoia and Paranoid States	1	1	—	—	1
Senile Psychosis	1	1	—	—	1
Presenile Psychosis	1	1	—	1	—
Psychosis of Other Demonstrable Etiology	2	1	1	1	1
Other and Unspecified Psychosis	7	4	3	3	4
PSYCHONEUROTIC DISORDERS	7	5	2	4	3
Hysterical Reaction Without Mention of Anxiety Reaction	2	2	—	1	1
Neurotic-depressive Reaction	2	1	1	2	—
Gastric Neuroses	1	1	—	—	1
Other Digestive Manifestations Specified as of Psychogenic Origin	1	—	1	1	—
Other Psychoneurotic Disorders	1	1	—	—	1
DISORDERS OF CHARACTER, BEHAVIOR, AND INTELLIGENCE	186	130	56	87	99
Pathologically Inadequate Personality	1	1	—	—	1
Idiocy	36	27	9	15	21
Imbecility	42	28	14	19	23
Moron	84	56	28	43	41
Borderline Intelligence	2	1	1	1	1
Mongolism	8	8	—	3	5
Other and Unspecified Types	13	9	4	6	7
TOTAL	223	154	69	107	116

portion of this group the disorder can be prevented or so handled as to make them useful citizens in their community.

The total number of persons with tuberculosis accepted is shown in the analysis of Infective and Parasitic Diseases (table 4). These figures are a wonderful tribute to modern medicine and the handling of pulmonary tuberculosis. Early in this program we established definite criteria for the acceptance or rejection of these patients whether

Table 4.—Infective and Parasitic Diseases

Detailed Analysis — by Race and Sex

	Total	Race		Sex	
		White	Negro	Male	Female
TUBERCULOSIS	11	7	4	9	2
Pulmonary Tuberculosis	4	3	1	4	—
Tuberculosis, Unspecified Site	1	1	—	1	—
Tuberculosis of Bones and Joints	1	—	1	1	—
Late Effects of Tuberculosis of Bones and Joints	5	3	2	3	2
VENEREAL DISEASES	38	14	24	30	8
Juvenile Neurosyphilis	2	2	—	2	—
Other Cardiovascular Syphilis	7	2	5	7	—
Tabes Dorsalis	12	8	4	10	2
General Paralysis of Insane	1	—	1	—	1
Other Syphilis of Central Nervous System	11	—	11	7	4
Other Forms of Late Syphilis	5	2	3	4	1
OTHER DISEASES	46	32	14	24	22
Brucellosis	3	2	1	2	1
Meningococcal Infections	3	2	1	—	3
Poliomyelitis with Paralysis	5	3	2	4	1
Late Effects of Acute Poliomyelitis	31	22	9	16	15
Late Effects of Acute Infectious Encephalitis	4	3	1	2	2
TOTAL	95	53	42	63	32

or not they offered future possibility of rehabilitation. If they are totally disabled for any length of time, they are assumed to be permanently disabled; therefore, they are accepted for this program and are rechecked later.

The Venereal Diseases subdivision of this table presents another tribute to modern medicine. It is most surprising that of the 1,429, only 38 were accepted because of venereal diseases. Few of the diagnostic studies were conclusive enough to rule out the possibility of future cerebral spinal syphilis. Public Health agencies are making serious efforts to cooperate, but much improvement is yet to be made in this field.

Other Diseases is presented as a subdivision of table 4 because it is so pertinent to one of the real objectives of this paper. Of the 46 successful applicants in this group, 36 were accepted because of poliomyelitis. It is anticipated that the research in this field has reached such a stage that future generations will not find it necessary to apply for public assistance because of disability due to poliomyelitis.

Table 5.—Cancers, Tumor, and Other Neoplasms
Detailed Analysis — by Race and Sex

		Race		Sex	
	Total	White	Negro	Male	Female
Cancers	30	20	10	18	12
Other Neoplasms	9	7	2	5	4
Total	39	27	12	23	16

Table 5 shows the figures on Cancers, Tumor, and Other Neoplasms. That the number is small is rather surprising because a high percentage of the applicants accepted were in the usually considered cancer age.

Allergic, Endocrine System, Metabolic and Nutritional Diseases, presented in table 6, represents a most interesting group, particularly to those of us who practiced in the area when pellagra was a serious disease. Only one applicant with this diagnosis was accepted. The rarity of this disease today is due to *research*. Applicants with diabetes mellitus were never accepted unless the disease was in a far advanced and uncontrollable state, usually with complications. Bronchial asthma constitutes a problem for all physicians. The applicant, to be accepted, had to have the disease so severely that it was difficult or impossible to control with modern drugs. Although not noted in the analysis, bronchial asthma with severe pulmonary emphysema was usually considered as being totally disabling.

Table 6.—Allergic, Endocrine System, Metabolic, and Nutritional Diseases
Detailed Analysis — by Race and Sex

		Race		Sex	
	Total	White	Negro	Male	Female
Asthma	18	15	3	12	6
Nontoxic Nodular Goiter	1	1	—	—	1
Thyrotoxicosis	1	—	1	1	—
Myxedema and Cretinism	3	3	—	1	2
Diabetes Mellitus	14	9	5	8	6
Diseases of Pituitary Gland	1	1	—	—	1
Pellagra	1	1	—	—	1
Gout	1	1	—	1	—
Other Metabolic Diseases	1	1	—	—	1
Total	41	32	9	23	18

Table 7, Diseases of the Nervous System and Sense Organs, shows that Other Diseases of the Central Nervous System represents the largest single group in this classfication. Applicants with epilepsy in any form were not accepted if the disease could be controlled by drugs. On the other hand, those with paralysis agitans usually represented the sad few who were generally accepted. Under Other Cerebral Paralysis, there is little comment to be offered except that the percentage of extreme obesity was high. Time will not permit a discussion of obesity, but our statistics demonstrate that it is a serious problem.

Inflammatory Diseases of Central Nervous System is a subdivision of table 7 presented to direct attention to those frequently sad cases in many of which the disease could be prevented. Under Vascular Lesions Affecting the Central Nervous System, there were 63, in whom the disease was mostly well defined.

Arthritis and Rheumatism, Except Rheumatic Fever, a subdivision of table 8, Diseases of the Bones and Organs of Movement, presents one of the serious situations largely unanswered as yet by the medical profession. At present, rehabilitation seems to be the most hopeful answer for the national public welfare program.

Table 9, Congenital Malformations, is mentioned because most of the abnormalities are congenital in origin, or at least thought to be congenital. Though this particular group is not large in numbers, nevertheless, if we are to be effective in preventing total and permanent disability and saving this segment of society, we must study each

group separately and attempt to save its members regardless of relatively small numbers. By the law of problem and chance, in a period of a few years this group will be large.

A summary of the primary disabling condition by race and sex in the 1,429 applicants accepted is set forth in table 10, showing the percentage breakdown in connection with the numerical analysis and presenting a comparison of the sex incidence in the white and Negro races. It portrays the situation at a glance and shows where the largest problem is and where the attack must begin. For comparative study, table 11 is of interest. It shows the secondary disabling conditions as diagnosed by the examining physicians. That there was no secondary disabling condition in 49 per cent of the cases is noteworthy.

Magnitude of the Problem

Statistics of the State of Florida show that the State Department of Public Welfare comes third in the expenditure of public funds, receiving 17.081 per cent, with education receiving 27.5 per cent and the State Road Department 22.7 per cent. Unless there are greater advances in efficiency and quantity of modern machinery to increase materially the output, both agricultural and manufactured, and, in addition, an alteration of the tax burden, we will approach the state where the individual taxpayer between 18 and 65 can no longer support Aid to Dependent Children, the Blind, the Permanently and Totally Disabled and the Aged, as well as our various hospital programs for the indigent. It is almost

Table 7.—Diseases of the Nervous System and Sense Organs

Detailed Analysis — by Race and Sex

	Total	Race		Sex	
		White	Negro	Male	Female
VASCULAR LESIONS AFFECTING CENTRAL NERVOUS SYSTEM	63	50	13	39	24
Cerebral Hemorrhage	7	5	2	5	2
Other and Ill-defined Vascular Lesions Affecting Central Nervous System	56	45	11	34	22
INFLAMMATORY DISEASES OF CENTRAL NERVOUS SYSTEM	20	13	7	8	12
Intracranial and Intraspinal Abscess	1	—	1	—	1
Encephalitis, Myelitis, and Encephalomyelitis	4	4	—	—	4
Late Effects of Intracranial Abscess or Pyogenic Infection	5	3	2	2	3
Multiple Sclerosis	10	6	4	6	4
OTHER DISEASES OF CENTRAL NERVOUS SYSTEM	321	176	145	196	125
Paralysis Agitans	29	21	8	17	12
Cerebral Spastic Infantile Paralysis	48	30	18	29	19
Other Cerebral Paralysis	191	86	105	125	66
Epilepsy Petit Mal	5	2	3	2	3
Epilepsy Grand Mal	16	10	6	6	10
Epilepsy Other and Unspecified	13	10	3	6	7
Other Diseases of the Brain	4	4	—	3	1
Motor Neurone Disease and Muscular Atrophy					
Progressive Muscular Atrophy	3	3	—	1	2
Amyotrophic Lateral Sclerosis	3	2	1	3	—
Spinal Type of Muscular Atrophy	2	2	—	2	—
Other and Unspecified Manifestations	1	1	—	1	—
Other Diseases of Spinal Cord	6	5	1	1	5
DISEASES OF NERVES AND PERIPHERAL GANGLIA	3	3	—	2	1
Sciatica	1	1	—	—	1
Other and Unspecified Forms of Neuralgia and Neuritis	2	2	—	2	—
DISEASES AND CONDITIONS OF THE EYE	4	3	1	3	1
Cataract	2	1	1	1	1
Glaucoma	1	1	—	1	—
Blindness, One Eye, Not Specifically Defined	1	1	—	1	—
DISEASES OF EAR AND MASTOID PROCESS	6	4	2	4	2
Deaf Mutism	6	4	2	4	2
TOTAL	417	249	168	252	165

Table 8.—Diseases of the Bones and Organs of Movement

Detailed Analysis — by Race and Sex

	Total	Race		Sex	
		White	Negro	Male	Female
ARTHRITIS AND RHEUMATISM, EXCEPT RHEUMATIC FEVER	160	96	64	85	75
Rheumatoid Arthritis and Allied Conditions					
Rheumatoid Arthritis	91	57	34	47	44
Spondylitis Ankylopoietica	10	7	3	7	3
Osteoarthritis and Allied Conditions					
Osteoarthritis	31	14	17	19	12
Spondylitis Osteoarthritica	24	16	8	10	14
Other Specified Forms of Arthritis	2	1	1	2	—
Arthritis, Unspecified	2	1	1	—	2
OSTEOMYELITIS AND OTHER DISEASES OF THE BONE AND JOINT	15	10	5	10	5
Chronic Osteomyelitis	1	1	—	1	—
Other Diseases of the Bone	1	1	—	1	—
Internal Derangement of Knee Joint	1	1	—	—	1
Ankylosis of Joint	9	6	3	5	4
Other Diseases of Joint	3	1	2	3	—
OTHER DISEASES OF MUSCULOSKELETAL SYSTEM	35	25	10	25	10
Synovitis, Bursitis and Tenosynovitis with Mention of Occupational Origin	1	1	—	1	—
Other Diseases of Muscle, Tendon, and Fascia					
Myasthenia Gravis	1	1	—	1	—
Inborn Defect of Muscle	16	11	5	9	7
Other	6	4	2	5	1
Curvature of Spine	6	4	2	5	1
Clubfoot	3	2	1	2	1
Other Deformities	2	2	—	2	—
TOTAL	210	131	79	120	90

self-evident that if these tax burdens increase, the difficulty the individual taxpayer encounters in accumulating resources to care for himself after retirement will be near to insurmountable. Automatically then, the number of aged on the tax rolls will increase.

The apparent hope for remedying this situation is to reduce the number of indigents on the tax rolls. First, this problem is a big economic one and must be handled by education as well as improvement in opportunity for this group. We must begin a serious effort to learn why certain families are on relief over a period of years, frequently for several generations. Apart from statistical studies, no real effort has been made to answer this important part of our problem. Further and more intensive studies must be carried on to aid the disabled and older age group in securing employment. The third phase is to control, and when possible, eliminate, all forms of disabling diseases. Bradley Buell,[2] Executive Director of Community Research Associates of New York, said in a recent address:

"That the provision of service is not an end in itself;

"That our *modern* purpose should be to control and, hopefully, reduce the principal human problems for which the *modern* community must accept responsibility;

"That to this end services should be organized to 'prevent' or curtail the processes of deterioration which *sap* capacity for self maintenance, and

Table 9.—Congenital Malformations

Detailed Analysis — by Race and Sex

	Total	Race		Sex	
		White	Negro	Male	Female
CONGENITAL MALFORMATIONS					
Monstrosity	1	1	—	1	—
Spina Bifida and Meningocele	1	1	—	—	1
Other Congenital Malformations of Nervous System and Sense Organs	1	—	1	1	—
Congenital Malformations of the Circulatory System	2	2	—	1	1
Congenital Malformation of Bone and Joint	9	6	3	6	3
Other and Unspecified Congenital Malformations	4	3	1	2	2
TOTAL	18	13	5	11	7

conversely, 'rehabilitate' to higher levels of self-capacity those suffering from the results of these processes."

Four research studies are in progress under Mr. Buell, two in Minnesota, one in Washington County, Maryland and one in San Mateo, Calif. These are similar in character and continue to bring out certain phases of the over-all picture of community planning for human services.

The further value of research in an effort to eliminate our disabled is illustrated by a report made recently at hearings of a House appropriations subcommittee by Dr. Floyd S. Daft.[3] Director of the National Institute of Arthritis and Metabolic Diseases, Bethesda, Md. It has been demonstrated by scientists at the institute that galactosemia, a disease known for some time, which causes blindness, imbecility, or even death in infants, is due to the fact that these babies all inherit a blood defect wherein the newborn infants are unable to convert galactose into glucose — an enzyme deficiency. Careful observation of the infant in the first few days of life and the removal of milk from the diet will save the baby's life or the crippling defects. Thus alertness on the part of the physician in discovering this disease and the proper handling may save many of these infants who have previously been considered as having nonpreventable congenital defects. It is true that relatively they are not numerous, but an approach and attack must be made in such a group as well as in larger groups in order to reduce all groups with defects causing dependence.

Research Department Recommended

It is proposed that we appeal to the next session of the legislature to establish a research department in connection with and as a part of the Department of Public Welfare. Heading this division would be a full time physician who has an understanding of and an enthusiasm for this undertaking. Under him should be a trained medical social worker and a trained nonmedical social worker. This department should be handled in connection with the statistical research division now well established and doing excellent work. The head of the statistical research division should be a part of the medical research division as well as head of the statistical research. There should be a medical advisory board selected from the Florida Medical Association and selected with great care. The minimum number of members on this board should be five. In addition, there should be a general advisory board composed of

Table 10.—Summary of Cases Approved for Aid to the Disabled

July 1955 — March 1956

PRIMARY DISABLING CONDITION — BY RACE AND SEX

	Total	Per Cent of Total	White		Negro	
			Male	Female	Male	Female
I Infective and Parasitic Diseases	95	7	35	18	29	13
II Cancers, Tumor, and Other Neoplasms	39	3	19	8	4	8
III Allergic, Endocrine System, Metabolic, and Nutritional Diseases	41	3	18	14	5	4
IV Diseases of the Blood and Blood-forming Organs	3	—*	—	—	2	1
V Mental, Psychoneurotic, and Personality Disorders	223	16	78	76	29	40
VI Diseases of the Nervous System and Sense Organs	417	29	154	95	98	70
VII Diseases of the Circulatory System	305	21	107	52	75	71
VIII Diseases of the Respiratory System	21	2	17	1	2	1
IX Diseases of the Digestive System	8	1	6	1	—	1
X Diseases of the Genitourinary System	6	—*	1	2	3	—
XI Diseases of the Skin and Cellular Tissue	3	—*	2	—	—	1
XII Diseases of the Bones and Organs of Movement	210	15	76	55	44	35
XIII Congenital Malformations	18	1	7	6	4	1
XIV Symptoms, Senility, and Ill-defined Conditions	7	—*	1	1	2	3
XV Fractures, Amputations, and Other Disabling Conditions	33	2	17	7	4	5
TOTAL	1,429	100	538	336	301	254

*Less than one half of 1 per cent.

Table 11.—Secondary Disabling Condition in Cases Approved for Aid to the Disabled
July 1955 — March 1956

	Cases	Per Cent of Total	
I Infective and Parasitic Diseases	35		5
II Cancers, Tumor, and Other Neoplasms	9		1
III Allergic, Endocrine System, Metabolic, and Nutritional Diseases	57		8
IV Diseases of the Blood and Blood-Forming Organs	11		1
V Mental, Psychoneurotic, and Personality Disorders	52		7
VI Diseases of the Nervous System and Sense Organs	141		19
VII Diseases of the Circulatory System	195		27
VIII Diseases of the Respiratory System	21		3
IX Diseases of the Digestive System	43		6
X Diseases of the Genitourinary System	30		4
XI Diseases of the Skin and Cellular Tissue	5		1
XII Diseases of the Bones and Organs of Movement	82		11
XIII Congenital Malformations	9		1
XIV Symptoms, Senility, and Ill-defined Conditions	12		2
XV Fractures, Amputations, and Other Disabling Conditions	30		4
Total Cases with Secondary Disabling Conditions	732	51	100
Cases with No Secondary Disabling Condition	697	49	
TOTAL	1,429	100	

the State Director of Vocational Rehabilitation, the State Superintendent of Public Instruction, the Director of the Bureau of Tuberculosis Control, the State Health Officer, and others in fields pertinent to this research problem.

The two medical colleges in the state should be invited to participate in this research both in an advisory capacity and actively. The funds as appropriated should permit allocation to accepted agencies which are in a position to participate in long range research. The medical consultant to the Department of Public Welfare should, of course, be a consultant to the research department, and his services frequently should be sought to point out specific cases or groups of cases in which permanent and total disability is or is not allowable.

Physician's Key Role

That this research undertaking is a major problem in which the physicians of Florida are primarily involved, taking a leading part, is hardly questionable. Our failure to accept this challenge would probably result in such a research project being placed in the hands of others not nearly so well qualified. An example will point out one field in which we as physicians can help to eliminate permanent and total disability. One applicant applied for permanent and total disability on the basis of a heart condition. The form which was filled out for us gave a diagnosis of (1) "heart disease" and (2) "general debility." The social worker reported that the applicant had had a heart attack in 1948 and that he did not go out of the house; that he spent most of his time in bed listening to the radio; and that he was extremely pessimistic about his disability. His wife spent much of her time waiting on him. That type of diagnosis being unacceptable, he was referred to a most capable specialist in a neighboring city. This physician made a thorough examination and in summary said, "This applicant has no cardiovascular disease. . . . He has been the victim of faulty or loose medical advice." The physician further reported that he explained that the premature beats were of no significance and asked the applicant how he would feel if he had no heart trouble. According to the physician, his face lit up and he said, "I would be the happiest man in the world." The process of rehabilitation was started.

An example of another equally serious problem which must be met is a woman who at the age of 38 had an examination by a capable ortho-

pedist. She was advised to have orthopedic surgery, which would in no way jeopardize her life but would restore her to normalcy and make her a self-supporting citizen. She refused surgery. At the age of 48 she applied to the Department of Public Welfare as being permanently and totally disabled, and the orthopedist no longer advised surgery. She had to be accepted. How can we insist on surgery and how can we appeal to those needing surgery to accept when that surgery does not jeopardize their lives?

Another much more direct but important problem is illustrated by the fact that we have received applications from three idiots born successively in one family and, in another family, three serious mental defectives and a fourth subnormal mentally. I repeat, the problem is a serious one and must be met promptly.

Those who should initiate such studies and supervise the research are members of the medical profession. The physicians who are the consultants to the Department of Public Welfare badly need the cooperation and assistance of every physician in Florida. Each form filled out by one of you may occasion an injustice to a person applying for aid, or may add an unnecessary tax burden to the public. Every physician should bear his responsibility in this respect well in mind and should realize that he can make a great contribution to progress in this field by applying to the Department of Public Welfare for membership on an examining team. Thus he may participate actively in promoting this program.

Appreciation is expressed to Howard Croom, Director, and the staff of the Division of Research and Statistics of the Department of Public Welfare for compiling the statistical information here presented.

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The First Decade of Atomic Medicine

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The first decade of atomic medicine culminated in the Geneva Conference, an unprecedented scientific meeting where all the nations of the world pooled their knowledge of biomedical as well as atomic technology in the unclassified area. The contributions of the United States alone filled seven large volumes. What is the essence of the progress made in these past 10 years? Ionizing radiation, formerly confined to the laboratory, the hospital and the radiologist's office, has become of significance to the entire population of the globe. Mechanisms by which radiation affects living tissue have become much more clearly understood, and the problems of exposure to radiation have become more starkly outlined.

Influence on Related Fields

The stimulus of atomic energy has also greatly influenced certain related fields. Diagnostic and therapeutic radiology have been much stimulated and helped by the great wave of research that has rolled over the past 10 years bringing advances in technology and knowledge of radiation effects. The potential dangers in the field of industrial medicine have been successfully met by the atomic industry and give an example of how potentially hazardous industries can be rendered so safe as to be virtually hazard-free.

Moreover, there is a general awareness among both laymen and the profession that medical research adequately supported can produce impressive advantages. The atomic energy program was an outstanding factor in this respect. Up until the advent of World War II exposure to radiation was relatively limited, and interest in the field of radiation effects was slight. Now, however, with the awareness of radiation problems there has come a great stimulus in research and in obtaining a better understanding of the effects of radiation and a clearer appraisal of permissible dose limits. It is becoming increasingly clear that although through nuclear tests we are scattering minute amounts of radioactive materials widely, these are of minimal importance and far more significant are the radiations to which our popu-

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lations are being submitted through diagnostic and even commercial, such as shoe-fitting, devices.

There seems to be no stage of human development at which man is not to some degree subject to ionizing radiation. In utero the probing eye of the x-ray tube seeks to determine whether he is single or twins, head first or breech first. In infancy it checks him for possible abnormalities. In youth it aids in the setting of his broken bones or detects signs of tuberculosis. When he reaches the dignity and maturity of peptic ulcer, x-ray examinations of his gastrointestinal tract provide dosages of 40 r or more. When he is quieted in advancing years by his sclerosing coronaries, checks on heart size and degree of calcification of the vessels keep up a generous allotment of ionizing radiation.

Man's Adjustment to Changing Environment

It must be remembered that the total environment of man is slowly changing. If he comes to use atomic energy more and more, he will come into more significant contact with ionizing radiation from atomic sources and hence, should be prepared to reduce the amount of ionizing radiation that he has been receiving from other sources. This adjustment is part of the essential process of our learning to live with atomic energy.

It is essential that we have a better knowledge of the background radiation which varies significantly in various regions. Background radiation is contributed by such factors of natural radioactivity as the radium content of rocks and water, the naturally occurring radioactive isotopes of potassium in the soil and the cosmic radiations. In general, these add up to a total of about 10 to 15 r of total body radiation in a generation. This level of background radiation may vary several fold and is perhaps at its highest in the monazite sand region of Travancore in India, where studies are now underway to determine the effects of the relatively high background radiation level on the inhabitants.

Dire predictions have been made as to the effect on heredity of exposure to atomic energy. Some of these seem exaggerated, but the basic truth of the mutagenic effect of radiation is clear. As we add to our facts about mammalian genetics, better assessment of the magnitude of the problem can be carried out and means of meeting it devised. Radiation from atomic sources is still a small portion of the total received.

Practical Diagnostic and Therapeutic Uses

What have we learned thus far of value to your individual patients? From the standpoint of their protection, reduce the amounts of ionizing radiation that they receive: (1) do not irradiate the pelvis of the pregnant woman unless truly necessary; (2) if fluoroscopy must be done for any reason, keep the time reduced to a minimum; (3) do not use photofluorographic units repeatedly on the same patient. If chest x-ray surveys are to be carried out, see that the output of the x-ray tube is kept at a minimum. The new image intensifying devices will be most helpful in this regard.

Certain diagnostic tests taking advantage of radioactive isotopes have come to be of practical value. Thyroid uptake studies with I^{131} are of great value. Localization of tumors, particularly those of the brain, may be materially aided by the local concentration of radioactive iodine in them, usually combined with various substances or radioactive phosphorus. Radioactive iron is of great value in the study of certain anemias. Various radioisotopes have been used for the determination of circulation times.

From the therapeutic standpoint there is considerable limitation of utility of the isotopes. No miracle has been worked. Radiocobalt has proved a useful and inexpensive substitute for radium. I^{131} is effective in the controls of hyperthyroidism in cases not suitable for operation and is useful in the therapy of some advanced cases of cancer of the thyroid. Radioactive strontium is of some value in the superficial irradiation of certain lesions particularly about the eye. Radioactive phosphorus is the treatment of choice in polycythemia vera and occasionally of aid in some of the leukemias. Radioactive gold provides palliation of pleural and peritoneal metastases in a number of instances. Radioactive cesium is of potential value in radiation therapy, providing an intense and steady source of radiation in the 500-700 KV range.

Undoubtedly, as time goes on, many more practical uses will be found for these radioactive substances. At the present time, however, their chief value is in the field of research, where they are absolutely indispensable. The use of the tracer or the tagged atom has enabled us to understand intermediary metabolism with a degree of clarity that otherwise would have been impossible. Substances of relatively short life in the

metabolic cycle can be readily recognized. Not only are substances recognizible as to their occurrence, but they can be followed with great accuracy as to time and as to ultimate utilization.

A carefully measured amount of glucose could in the past be indirectly traced through the body's metabolic paths by urinary excretion, respiratory quotient and shifts in blood sugar level. If tagged with radioactive carbon atoms or tritium atoms, the glucose administered can be followed with great accuracy through all its metabolic steps and those steps in addition accurately timed. Thus, the research worker has been provided with a tool that greatly expands the powers of his laboratory procedures.

The Harvard Medical School.

Adenocarcinoma Arising from an Anal Gland

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The role of the anal glands and their ducts in the possible development of perianal infection and anal carcinoma has only recently been brought to the forefront. A review of the literature on the subject of primary adenocarcinoma of the anus reveals but three cases reported since Scarborough[1] first presented a case of malignant tumor deep in the ischiorectal fossa and referred to the anal gland as the site of origin. This case was presented in 1941.

Burke, Zavela and Kaump[2,3] in 1951 presented a case of primary adenocarcinoma of low degree malignancy arising from the perianal glands. Gupta[4] in 1952 implicated the anal ducts in the formation of a malignant neoplasm in a 50 year old man.

The first reference to the anal glands was made by Hermann and DeFosses[5] in 1880. They described the anatomy of the anal glands and suggested their possible role in the development of perianal infection. In 1914 Johnson[6] published a treatise on "The Development of the Rectum in the Human Embryo" and illustrated their structure and location.

Many other authors have subsequently reported their findings on this subject. Some of the conclusions drawn from the combined studies are:[7-11]

1. These tubular-acinar structures (anal ducts and anal glands), lined with columnar epithelium, exist in certain lower animals and man. They have been demonstrated in about 50 per cent of human anal canals. Postnatally in the human being, the secretory cells disappear from the anal ducts. Not more than eight such ducts are to be found in any one rectum, and most of the ducts have their orifices in the anal crypts, in the posterior portion of the anal canal.

2. From the openings in the anal crypts, the anal glands and ducts course outward and downward often penetrating the internal anal sphincter, the external anal sphincter and the levator muscles. The glands manifest a wide individual variation as to number, depth of penetration and contour.

3. These glands are frequently the site of inflammatory reaction of varying degree. They are found to be involved in cases of anal cryptitis, ischiorectal abscesses and anal fistula. They provide the pathways for lateral spread of perianal infection.

4. These ducts and glands are presumed to be preformed vestigial remains of large sexual scent glands found in lower animals. Some authors do not agree with this assumption and believe that these glands are active in the human being as secretory structures throughout life. They believe that these glands are active by cycles and only a small number are active at any given time.

5. In the simple tubular forms the glands are lined with stratified squamous and transitional epithelium. In the more complex glandular forms they are lined by columnar and low cuboidal epithelium.

6. The glands are analogous to the deep intramuscular glands found in certain other locations in the intestinal tract such as the esophagus.

7. These glands are rarely subject to tumor formation.

Report of Case

A white woman, aged 39, was admitted to the hospital with rectal complaint. She gave a history of rectal protrusion with occasional moderate bleeding following passage of stools for at least eight years. She associated the onset of symptoms with the birth of her last child.

Physical examination, including a proctosigmoidoscopy, gave negative results except for large internal and external hemorrhoids with moderate prolapse of the rectal mucosa.

Laboratory and roentgenographic studies were normal.

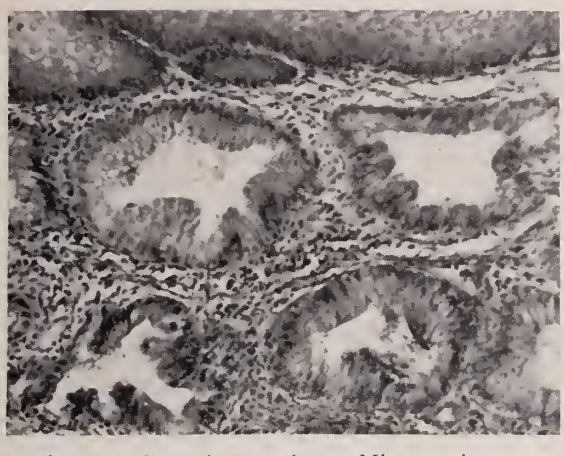

Fig. 1. — Operative specimen, Microscopic appearance of adenocarcinoma, grade 1, anal gland.

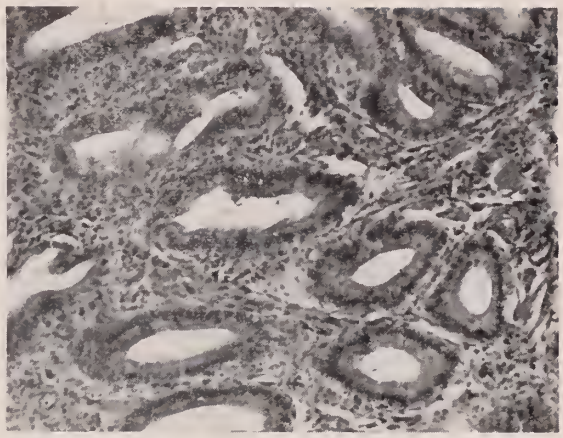

Fig. 2. — Operative specimen. Microscopic appearance of deep portion of tumor. Adenocarcinoma, grade 1, anal gland.

An amputative type of hemorrhoidectomy with wide excision was performed. The excised tissue was submitted for examination. Every piece of tissue removed during anorectal surgery should be submitted to the pathologist for examination as unsuspected conditions may otherwise be overlooked.

The specimen consisted of two hemorrhoidal tags 5 by 3 by 2 cm. in size. One of the pieces showed a firm yellowish gray area approximately 1 cm. in diameter some distance from the rectal mucosa. Repeated sections through this area showed large numbers of poorly formed irregular glands containing numerous mitotic figures. These irregular glands were seen deep in the tissue as well as on the surface. The epithelial elements tended to be of the flattened cuboidal type found in carcinoma of the anal gland in contrast to the high cuboidal type seen in low grade malignant lesions of the mucosa in the colon. Mucin stains on this material were not done.

It was my conclusion, and it was also the impression of the pathologist, that these findings established the presence of an adenocarcinoma of the perianal gland type which was of low grade malignancy.

The patient had an uneventful convalescence and was discharged from the hospital on the seventh postoperative day. The tumor was small, but the tissue in the area was widely excised. Since it was of low grade malignancy, I thought that the operation had been adequate.

Since the operation one year ago, the patient has remained well. Periodic examinations have revealed no evidence of recurrence.

Summary

The literature on the anal ducts and glands in relation to their possible role in the development of perianal infection and tumor formation has been reviewed and summarized.

A case of adenocarinoma arising from an anal gland is reported.

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Medical District Meetings

District A	Tallahassee	October 30
District B	Ocala	October 31
District C	Tampa	November 1
District D	West Palm Beach	November 2

Volume XLIII
Number 3

Surgical Aspects of Jaundice

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PENSACOLA

The practice of medicine has developed increasingly into a team battle by the branches of the profession against the various disease entities. Nowhere is this battle more apparent than in the conditions of which jaundice is a manifestation and a symptom.[7] Jaundice is a formidable and versatile antagonist, as shown all too clearly by consideration of the prognosis: "A patient who has become jaundiced, regardless of age, has approximately 3½ chances out of 10 to recover."[1] These figures were derived from the analysis of 400 consecutive cases. Jaundice sometimes presents a weak front, but all too often it mounts a dangerous or lethal offensive against both patients and physicians. Jaundice as a ruthless aggressor deserves serious respect and a maximum effort counteroffensive. One attempts to designate cases as either medical or surgical by clinical diagnostic acumen, laboratory tests, and roentgen studies. This distinction must be made as accurately as possible since this is a field in which defeat is more clearcut than is victory. The battle with jaundice may result in a well patient or a dead patient, or it may result in no victor at all — only survivors.

To insure a low morbidity and mortality rate in jaundiced patients, more intensive study and treatment are mandatory than in almost any other class of patients.[35,36] A useful classification divides jaundice into three types as follows: (1) prehepatic, (2) intrahepatic and (3) posthepatic.[28] The prehepatic and the intrahepatic types come under the medical division, and will be discussed by another member of this panel, Dr. Garmany. The posthepatic or obstructive type of jaundice belongs to the surgical group, and my discussion will be limited to this type. Surgical jaundice may be divided into two groups:[20] (a) intraluminal, such as stones, strictures (congenital or acquired), or neoplasms; and (b) extraluminal, such as pancreatitis, carcinoma of the head of the pancreas, or other causes of extrinsic pressure such as metastatic nodes.

A percentage breakdown of all the various types of jaundice is approximately as follows:[7] stones 25 per cent, carcinoma 30 per cent, intrahepatic 30 per cent, hemolytic 10 per cent,[6] and strictures, atresias, and other rare forms in the remaining 5 per cent. The sexes are equally affected.[31] The present widespread use of Thorazine has lent interest to the reports of an apparently new type of obstructive jaundice.[4,29] This occurrence is of twofold interest: first, in that the jaundice is an occasional complication of chlorpromazine therapy, and second, that, although it is obstructive in type, the treatment is nonsurgical. It results apparently from bile stasis or sludge and is treated successfully by withdrawal of the drug and supportive measures.

Diagnosis

The diagnosis of the type of jaundice rests upon meticulous history taking, physical examination and the aid of the laboratory and roentgen studies. In 1926, Lord Moynihan, one of the greatest surgeons of his or any other era, was quoted as having said, "No one living is infallible in the differential diagnosis of obstructive jaundice."[30] This observation is as true today as it was then. Nothing replaces an adequate history.[3] It is the most important of all diagnostic procedures. In spite of the modern diagnostic aids, its importance is as great today as in Lord Moynihan's time.

The history is developed about the presence or absence of pain, loss of weight, color of stools, color of urine, recent exposure to intravenous fluids, recent surgery, medications, exposure to rodents, and exposure to other cases of jaundice. Age is an important factor in diagnosis since obstructive jaundice occurs more often in middle-aged and elderly persons, whereas hemolytic and hepatocellular jaundice are more common in the younger age groups.[25] In newborns, erythroblastosis fetalis and atresias are more common forms of medical and surgical jaundice than are cases of inspissated bile or neoplasms.[9,11,14] The presence of pruritus is believed by many observers to be rare in cases other than obstructive jaundice, while other observers consider it of no diagnostic importance.[28,32] The necessity for brevity

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prevents my discussing in more detail the important points in history taking.

The physical examination centers about the size of the liver and spleen, the presence or absence of a palpable gallbladder, evidence of primary malignant disease elsewhere, presence of vascular signs such as spiders, and collateral portal circulation. Courvoisier, who lived from 1843 to 1918, set forth a law before the turn of the century which is still the one most valuable aid in physical diagnosis. This French surgeon stated that jaundice with a palpable gallbladder indicates malignant obstruction, and that in jaundice a nonpalpable gallbladder indicates calculi. In making a dogmatic diagnosis, however, one must ever keep in mind the versatility of jaundice, as any of the details of the history or physical examination may seem pathognomonic yet may be vastly deceptive and misleading. Courvoisier's law of course has many exceptions and is more nearly a guiding principle than a law.

Laboratory procedures form a most valuable aid in jaundice. They will be discussed in detail by the internist on this panel. In my work I prefer a battery of liver tests which includes the following: cephalin cholesterol flocculation, thymol turbidity, serum bilirubin, urine urobilinogen and bile, serum alkaline phosphatase, albumin-globulin ratio, and prothrombin time. Liver needle biopsy and biopsy and duodenal drainage have definite places in the diagnostic armamentarium.[10,33]

The use of preoperative roentgen studies in cases of jaundice consists of scout plates of the abdomen for possible calculi, along with contrast medium studies to rule out sites of primary malignant disease in the gastrointestinal and genitourinary tracts. Operative cholangiography has proved often to be of great assistance to the surgeon at the operating table by pointing out the exact location and character of an obstruction. This technic was first demonstrated in 1929 by Cotte and made widely known by Overholt.[12,17,23,24]

Treatment

Exploration of the common bile duct was first suggested by Langenbeck in 1884 and performed later in the same year by Kümmell.[18] The present operative technic represents a gradual evolution of details, but has differed little in principle since that time. A perusal of the literature of the 1930's, however, shows a considerable difference today in the methods of laboratory procedures in obstructive jaundice. A much greater change has occurred in the preoperative and postoperative management.

Today intensive blood, protein and electrolyte replacement, along with the vitamin K preparations, and preoperative antibiotics have removed much of the danger of surgery in jaundice. These therapeutic measures along with better anesthesia and the larger amounts of blood available at surgery have lowered the mortality rates to compare favorably with those of other surgical procedures of similar magnitude.

The treatment of jaundiced patients should be undertaken with a full realization of the serious implications which the diagnosis of jaundice carries. The absolute necessity for full, energetic cooperation and teamwork between the family doctor, the surgeon, the anesthesiologist, the pathologist and the roentgenologist cannot be emphasized too strongly.

Summary

The surgical indications in jaundice are:

1. Obstruction by a stone, proved or suspected
2. Acholic stools proved consistently complete
3. Jaundice following surgery in the upper portion of the abdomen
4. Postoperative biliary fistulas
5. Occasional undiagnosed cases in which exploration is the only choice.

The common contraindications, to name a few, are:

1. Cases in which the patient has received blood or plasma in the previous four to to six months.
2. The presence of the physical signs of cirrhosis, such as cutaneous spiders, edema, or collaterals to the portal circulation.
3. Severe prolonged jaundice with evidence of normal color of the stool and urine.
4. Lack of response to vitamin K in the face of prolonged prothrombin time.

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Normal Adult Red Blood Cell Count and Hemoglobin Value in South Florida

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An accurate normal red blood cell count and hemoglobin value for adult males and females is of obvious clinical importance. Only by knowing the normal and having it for a reference can one evaluate the abnormal. It is of disturbing note that variations of considerable degree still exist from hospital to hospital, and from one private office laboratory to another, insofar as reference normals of red blood cell count and hemoglobin are concerned. They are in large measure due to the fact that many physicians unknowingly are using figures obtained in a study made almost 100 years ago. More recent data provide accurate revision of this older work; yet the adoption of these correct values has been alarmingly slow.

Recently with the rebuilding of a hospital laboratory, data for the normal red blood cell count and hemoglobin values for the South Florida area had to be determined. This determination became necessary because of the fact that an unusually large number of anemias had been reported or diagnosed, in this, an otherwise ordinary and usual private hospital. The reference figures which had been previously used in this institution for normal were the ancient ones referred to, namely 5.0 million red blood cells and 15.5 Gm. of hemoglobin per cubic millimeter. The present study reflects the values obtained in the evaluation of 150 normal adult males and females who had resided in the South Florida area for six months or longer.

Material and Methods

The case material utilized consisted of healthy adult men and women drawn from the registered and practical nurses, orderlies, technical help in the hospital laboratories, interns and practicing physicians. All of these people had been well and had resided in the state of Florida for longer than six months. This period of time was adopted to allow adaptation to the climate and other pertinent living conditions of the area. All participants were older than 18 and younger than 55 years of age.

Hemoglobin determinations were performed using the Coleman Junior Spectrophotometer. Prior to this study, the machine was carefully calibrated using standard iron solutions prepared

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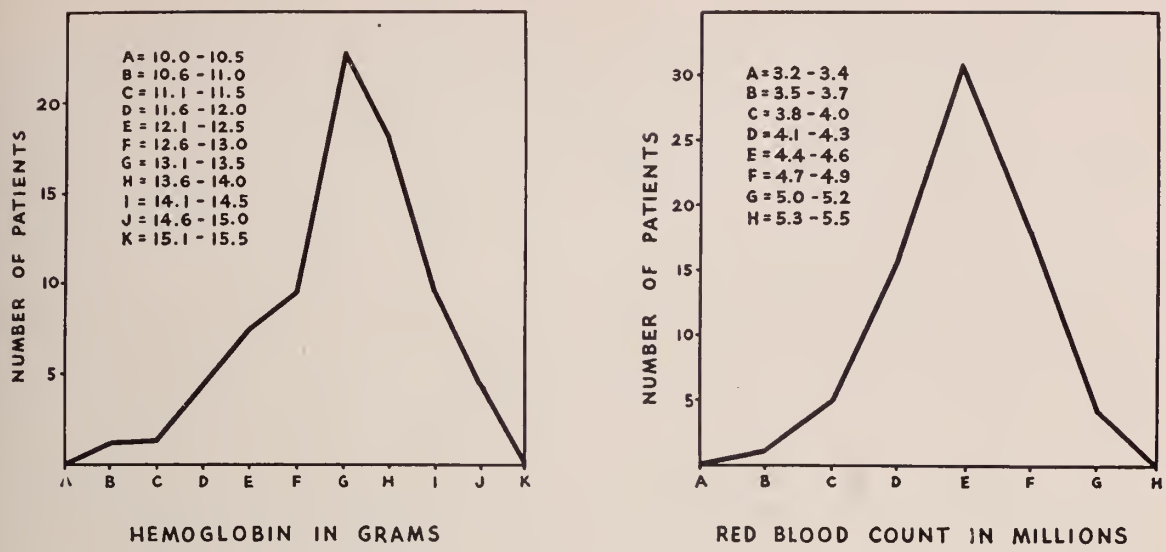

Fig. 1. — Distribution curve of 75 normal female red blood cell count and hemoglobin determinations.

according to the Wong method. All determinations were made in duplicate. Only Yankee certified pipets were used for the red blood cell counts. The hemocytometers were of the approved Neubauer type. One technician participated in the study. She performed every examination with close check in the duplicate determinations. There was thereby avoided the person to person variation that might be encountered with multiplicity of technical help.

Results

Group A — Females.—There were 75 normal adult females studied. Figure 1 illustrates the distribution curve which was obtained. The mean hemoglobin value was 13.2 Gm. The standard deviation is 0.897. Ninety-five per cent of the hemoglobin determinations performed were within the range of 11.29 to 15.08 Gm. The mean red blood cell count obtained was 4.5 million. The standard deviation is 0.309. Ninety-five per cent of the red blood cell count determinations performed were within the range of 3.89 to 5.11 million.

Group B — Males.—There were 75 normal adult males studied. Figure 2 illustrates the distribution curve which was obtained. The mean hemoglobin value was 14.33 Gm. The standard deviation is 0.835. Ninety-five per cent of the hemoglobin determinations performed were within the range of 12.66 to 16.00 Gm. The mean red blood cell count was 4.8 million. The standard deviation is 0.310. Ninety-five per cent of the

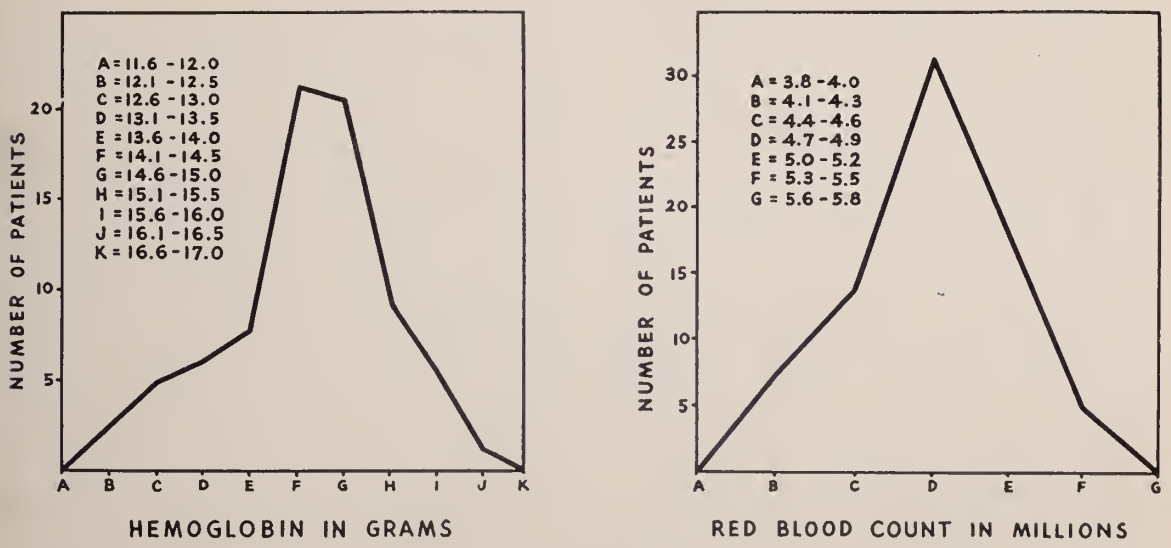

Fig. 2. — Distribution curve of 75 normal male red blood cell count and hemoglobin determinations.

red blood cell count determinations performed were within the range of 4.18 to 5.42 million.

Comment

A complete blood cell count is a routine procedure in most hospitals today. Its value, however, is dependent not only upon the ability of the technician, and the validity of her method, but also upon the proper knowledge of what constitutes normality. This present study again presents the fact that the values, 5.0 million red blood cells and 15.5 Gm. of hemoglobin per cubic millimeter, are higher figures than should be used for normal.

The mean normal hemoglobin value for adult females is 13.2 Gm. The distribution curve is such that 95 per cent of all normal female hemoglobins will lie between 11.29 and 15.08 Gm. The mean normal red blood cell value for adult females is 4.5 million. The distribution curve is such that 95 per cent of all normal female red blood cell counts will lie between 3.89 and 5.11 million.

The mean normal hemoglobin value for adult males is 14.33 Gm. The distribution curve is such that 95 per cent of all normal male hemoglobins will lie between 12.66 and 16.00 Gm. The mean normal red blood cell value for adult males is 4.8 million. The distribution curve is such that 95 per cent of all normal male red blood cell counts will lie between 4.18 and 5.42 million.

Summary

Attention is called to the fact that there unfortunately still remains incorrect and widespread variation in the utilized values for normal red blood cell and hemoglobin determinations. The results of this study using 150 normal adult men and women residing in South Florida are presented. The correct values to be used as reference normals for red blood cell and hemoglobin determinations are stressed. It is to be hoped that a uniform and correct norm will be adopted in all hospitals and private laboratories and offices.

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ABSTRACTS

Quantitative Identification of Urinary Calculi. By Reid H. Leonard and Arthur J. Butt. Clinical Chemistry 1:241-248 (Aug.) 1955.

These authors state that urinary calculi may be identified by quantitative methods in regular clinical use. Most specimens may be identified by determination of calcium, phosphorus, and oxalic acid, while the less frequent types may require a determination of ammonia and soluble nitrogen. In addition to the quantitative determinations, two observations and four qualitative tests assure accuracy in identification of calculi. The analytical compositions of the compounds ordinarily found in calculi are tabulated.

The procedure is outlined, including preparation, calcium determination, phosphorus determination, oxalic acid determination and auxiliary determinations.

For purposes of interpretation, urinary calculi are grouped as oxalate, phosphate, mixed oxalate-phosphate, and nitrogen-containing. Tables presenting representative analyses and interpretations accompany the discussion of each group.

In summary, the authors conclude that quantitative determination of calcium, phosphorus, and oxalic acid, assisted by occasional determination of ammonia nitrogen and insoluble nitrogen when indicated by qualitative tests, provides a means of computing the component substances of calculi. The determinations may be performed by slight modifications of the methods in use in the routine clinical chemistry laboratory, although flame photometry is particularly convenient for the determination of calcium.

Chronic Peptic Esophagitis. By Donald F. Marion. South. M. J. 48:1013-1016 (Oct.) 1955.

In this discussion of chronic peptic esophagitis the author points out the difficulty of evaluation of therapy and observes that diagnosis and response to therapy can be evaluated objectively and accurately only if initial and follow-up esophagoscopy is employed, the flexible viewing esophagoscopes as yet not being used to any great extent by internists and gastroenterologists. He reviews and outlines factors which may lead to the occurrence of this disease, its degrees and varieties, and its complications.

Experiences in the management of 5 cases of varying degrees of severity, followed for 18 to 36

months, are reported. A suggested medical treatment program is outlined, and it is concluded that good correlation between subjective and objective evidence of improvement or failure after treatment is not observed in this group. The necessity of prolonged follow-up despite subjective improvement is stressed. Case 5 of the series reported demonstrates the effectiveness of subtotal gastric resection in the management of certain severe and complicated cases.

The concluding observation is that the medical regimen must be followed for many years if progression of esophagitis is to be prevented. This is true to an even greater degree than that which obtains in the medical management of duodenal ulcer since the incompetent sphincter mechanism persists as a constant threat to exacerbation of the healed or quiescent lesion.

Rheumatic Fever — Diagnosis, Prophylaxis, and Therapy. By Milton S. Saslaw, M.D. J. A. M. A. 159:653-656 (Oct. 15) 1955.

The various manifestations of rheumatic fever are discussed in some detail and tabulated under the headings of major and minor (clinical and laboratory). The different diagnostic aids also are reviewed. In particular, the responses to Trafuril are presented. This test for rheumatic activity has been developed and under study by Saslaw and Streitfeld for a year and a half at the National Children's Cardiac Hospital in Miami. They have found that when a 5 per cent ointment of Trafuril (the tetrahydrofurfuryl ester of nicotinic acid) is applied to the skin, in normal subjects and patients with inactive rheumatic disease and congenital heart disease hyperemia, with or without edema, develops at the site of application — a typical (normal) reaction. In contrast, in patients with rheumatic activity there is a nontypical response characterized by failure of the skin to redden or by blanching. Preliminary results seem to indicate that skin testing with Trafuril may be of value in distinguishing active from inactive cases of rheumatic fever.

Prophylaxis is discussed from the viewpoints of who should receive it, how long preventive measures should be used, and what drugs and what doses are to be used. Since there is no known direct preventive measure, prophylaxis is aimed at preventing infections with group A beta hemolytic streptococci, which precede initial or recurrent attacks of rheumatic fever. Sulfadiazine and penicillin are regarded as the most effective prophylactics at present.

Therapy in four stages of the disease is outlined: treatment of (1) acute streptococcic infections, (2) the active phase of the disease, (3) the patient during convalescence, and (4) the late stages of the disease when cardiac involvement occurs.

A New Method for the Treatment of Peripheral Vascular Disease. By James F. Lyons, M.D., Burton Meadows, M.D., and Maurice Fuchs, M.D. South. M. J. 48:811-819 (Aug.) 1955.

Mechanical means of the past for the stimulation of the peripheral circulation have been found wanting. A new device, more physiologic, which may fare better, is the Syncardon. This new apparatus was developed by Dr. Maurice Fuchs, University of Bern, Switzerland, one of the authors of this article.

This device applies external pressure to an extremity for an exact, measured time and in perfect synchronization with each pulsation from the heart. By applying measured pressure over a part of an extremity at exactly the right time following each heart beat, the arterial pulse wave is boosted or reinforced and more blood is forced through any small vessels that are still patent or that are capable of dilatation. Through this rhythmic blood flow it appears possible to increase gradually the size and capacity of these vessels. The key point is in the timing. If improperly timed, the application of external pressure may actually impede rather than augment the peripheral flow of blood.

In addition to the mechanism of action, the diagnostic application, treatment and results are discussed. The diseases treated and the results obtained by Drs. Lyons and Meadows in Coral Gables are tabulated. In view of their gratifying results, a thorough investigation of this new mechanical and electronic device, the Syncardon, is advised. Eight illustrative cases are described.

Abscess of the Epiglottis, *Problem in Differential Diagnosis.* By Nina C. Ellenbogen Raim, M.D., Jerome Raim, M.D., and Louis Lytton, M.D. J. A. M. A. 159:1289-1290 (Nov. 26) 1955.

A case of Pseudomonas abscess of the epiglottis, proved by smear and culture, is reported. It illustrates an actual problem in differential diagnosis between an acute bronchial asthmatic attack and an acute upper respiratory obstruction. In

this case a history of bronchial asthma was present, along with that of frequent attacks of acute tonsillitis. Asthmatic rales as well as tonsillar and pharyngeal injection were present. Dyspnea was evident, but no retraction could be seen. A diagnosis of an acute asthmatic attack was made, but the more urgent pathology of epiglottic abscess, edema, and upper respiratory obstruction was not noted until later. The causative organism is interesting in its rarity.

An Evaluation of the Serum Iron in Liver Disease. By Chauncey M. Stone, Jr., M.D., John M. Rumball, M.D., F.A.C.P., and Claire P. Hassett, A.B. Ann. Int. Med. 43:229-240 (Aug.) 1955.

The purpose of this paper is to report the serum iron levels in 61 patients with hepatic disease. In this series there were 17 patients with acute viral hepatitis, 34 with portal cirrhosis, and 10 with obstructive jaundice. A total of 147 serum iron determinations was made on the 61 patients, and the methods employed and the results obtained are described. The literature is reviewed and the serum iron levels in hepatic diseases as reported in the American literature are tabulated. Two illustrative cases are presented.

The authors conclude that the serum iron level is helpful in the differential diagnosis of jaundice and should replace less specific tests. They believe that elevated serum iron levels in acute hepatitis are probably associated with liver cell necrosis and that the late appearance of the maximal rise of serum iron level in acute hepatitis suggests a more prolonged clinical course.

Succinic Dehydrogenase Activity, Protein Bound Sulfhydryl and Disulfide Groups in Squamous Cell Carcinoma of the Skin. By Alvan G. Foraker, M.D., and William J. Wingo, Ph.D. Surg., Gynec. & Obst. 101:346-352 (Sept.) 1955.

In a series of 38 cases of squamous cell carcinoma of the skin, the occurrence and distribution of protein-bound sulfhydryl and disulfide groups and of succinic dehydrogenase activity were studied. The results showed: (1) Sulfhydryl groups and dehydrogenase activity, both related to vital phases of cell function and growth, were found in all viable cells. (2) Evidence of dehydrogenase activity diminished as the cells (normal and neoplastic) evidenced maturation. (3) Disulfide groups, related to cell keratinization, were found in maturing and keratinized cells, normal and neoplastic. These histochemical technics have emphasized cell properties relating to growth, to neoplasia, and possibly to radiosensitivity.

Intravenous Urography Using Mixtures of Radiopaque Agents. By Benedict R. Harrow, M.D. Radiology 65:267-270 (Aug.) 1955.

In this study it was found that mixtures of Neo-Iopax and Diodrast proved to be a safe routine agent for intravenous pyelography, producing fewer side reactions than either drug alone and affording an increase in film density in 30 cc. amounts. Even 50 to 60 cc. was well tolerated and increased x-ray contrast. With all contrast substances and with the mixtures, secretory Tm is exceeded (for only a short period with small amounts), but the actual urine molecular concentration is limited to about a 0.2 molar solution by an osmotic diuresis and by a supersaturation of iodides in the urine. Roentgen density improved with larger amounts (50 to 60 cc.) because of an increase in diuresis, even though urine iodide concentrations did not increase significantly as demonstrated by specific gravity determinations. Urokon 70 per cent, although having minor disadvantages of temporary true and false proteinuria, arm pain and antecubital thrombophlebitis, produced a somewhat greater x-ray density because it contains more iodine to each molecule than the other agents. The only means of improving the urographic drugs is to increase the number of iodine atoms per molecule and to use large-sized molecules, like inulin, excreted by glomerular filtration.

It is emphasized that no matter what agent is used, dehydration over 16 to 18 hours is important and adequate compression is most essential for obtaining high quality films. In dilating and filling the calyces, compression need be applied only two minutes if performed properly. Compression hydronephrosis is greatest in the right kidney in women. The haphazard use of compression by many technicians has sometimes brought it into disrepute.

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Research Chain Reaction Chemistry Comes of Age

Being constantly on the watch for the chance reaction that may lead to a discovery is a characteristic of the scientific mind that has made a vast contribution to this "Age of Scientific Research" — which also may be called the "Golden Age of Medicine." Usually, well organized painstaking research along clearly defined lines, too often with each great success prefaced by a thousand failures, is the method by which modern science achieves its goal. Sometimes, however, a single chance discovery starts a chain reaction of discoveries that open up a new era of scientific progress.

The year 1956 marks the one hundredth anniversary of such a discovery. Just a century ago, William Perkins, an 18 year old student at home from college on Easter vacation, rigged up a crude little laboratory in the attic of his father's house in Scotland. There he undertook to make synthetic quinine from coal tar derivatives, but all he got in the bottom of his test tubes was a sticky black mass. As he cleaned out the tubes with alcohol, he noticed that one of them turned a beautiful delicate purple. The thought occurred to him that this color might make a good dye.

The boy chemist was indeed right. By synthesizing the first coal tar dye, he had made a vital discovery in organic chemistry. Soon this first important artificial dye in history became so fashionable that it lent its name to a whole period — the Mauve Decade. Perkins became rich and was knighted by Queen Victoria. His discovery, however, had only begun to play its historic role in the drama of scientific progress.

By dramatizing the potential of chemistry for man's betterment, the discovery made by the young Britisher gave new impetus to the solution of many difficult problems. Coal tar, the source of the aniline oil used in his experiment, previously discarded as waste, now became a key material as a source of high quality dye. Far more important, the fledgling scientist had tapped the wellspring of organic chemistry, a science deeply affecting the lives of all for it embraces the infinite combinations of carbon with hydrogen, oxygen, nitrogen and other elements — complex structures basic in all life.

Pasteur's germ theory of disease ranks among the ten greatest discoveries in the history of mankind. Yet if Perkins had not make his discovery

first, the monumental research of Pasteur could not have been made for it depended upon the property of coal tar dyes to stain bacteria selectively, thereby making possible the accurate study of microbes under the microscope.

Perkin's discovery gave impetus to research which produced some of the compounds that have played a major role in the medical advances of the twentieth century, as well as in many other fields. Medicinal chemicals such as sulfonamides, hormones, penicillin, and the whole array of "wonder drugs" are among the contributions of present day chemistry. Millions of lives have been saved and the national health picture materially brightened because chemistry has woven a brighter world for children and adults.

As research has been its inspiration, so diversification has become the nature and philosophy of the chemical industry. Fortunate results and consistent progress have resulted from unremitting effort and creative scientific imagination. Present chemical wonders are the result of research that has proved the chemical industry both friend and indispensable servant to all people. Surely chemistry has come of age today.

Yet the chain reaction of research continues to pyramid. Doubtless the atomic age will not need to produce another boy prodigy like Perkins, whose unrewarded attic search for synthetic quinine to cure man's ills has helped to reshape destiny. Science has become infinitely more intricate and purposeful than when he made his dramatic discovery. All research is a voyage to the edge of the unknown. Who can say what discoveries will be made there by scientists endowed with training, skill and imagination in the century now dawning?

Favorable Internal Revenue Service Ruling

A regulation of particular importance to physicians has recently been issued by the U.S. Internal Revenue Service. The regulation, which became effective on August 9, provides that expenditures for education are deductible if they are for a "refresher" or similar type of course taken to maintain the skills directly and immediately required by the physician in his employment or business. To meet this requirement, an educational course should be designed for established medical practitioners to help them keep abreast of current developments in the profession; it should be of short duration; it should not be taken on a continuing basis, and it should not carry academic credit. Education designed to prepare the practitioner to enter a specialty will not be acceptable.

A physician who travels away from home primarily to obtain "refresher" education may deduct his expenditures for travel, meals and lodging while away from home. It is emphasized, however, that expenses for personal activities such as sightseeing, social visiting or entertaining, or other recreation are not allowable.

This favorable ruling marks the culmination of efforts made over a long period of time by the Law Department of the American Medical Association to get the Internal Revenue Service to issue such a regulation permitting physicians to deduct their expenditures in taking postgraduate "refresher" courses.

Impressions of White House Conference on Education

Perennially, the nation is particularly school-minded in September. This year legislative aspects of the educational problems that beset the country have loomed large and have led interested citizens to ponder on educational trends.

Last year Dr. George S. Palmer and Dr. Paul J. Coughlin, both of Tallahassee, represented the Florida Medical Association at the Florida Pre-White House Conference on Education. Dr. Coughlin was chosen to represent the State of Florida at the White House Conference in Washington. His impressions of that meeting are timely as schools are this month everywhere opening their doors to begin a new school year.

"The Conference," commented Dr. Coughlin, one of two physicians among the 2,000 delegates from throughout the nation, "was an extremely interesting and stimulating one. . . . It was refreshing to note how many of the members actually were far more interested in getting back to the basic principles of teaching the fundamentals and a sense of responsibility and moral values. There is a definite trend back toward the material to be studied, rather than the getting lost in the methods used. In the long run, I think this will be refreshing, not only to education itself, but also to all the like fields such as medical education and in the production of doctors with the type of responsibility which we expect our physicians to have. I also believe that if this trend is continued, there is hope for a slowing down process of inroads of governmental interference in all spheres of human activity, including medicine."

Sears-Roebuck Foundation Revolving Assistance Fund

Physicians in Florida who are seeking an opportunity to improve existing facilities or to establish themselves in private practice in rural or suburban areas will be interested to learn of the schedule for processing applications recently announced by the Sears-Roebuck Foundation for its Revolving Assistance Fund. The purpose of this fund is to make loans to physicians desiring to establish or improve medical facilities in areas where the medical care is inadequate. The Foundation is now accepting applications for the last half of 1956. Those received before October 1 will be acted upon by December 15. For applications received later the cut-off date is April 1, 1957, and they will be acted upon by June 15.

The October cut-off date is ideal to aid those established physicians who have poor medical facilities and are now in a position to incur the responsibility of building or improving their medical units. The April cut-off date is convenient for graduating interns since loans are approved in June, the month in which they usually are graduated.

In cooperation with the American Medical Association, the Sears-Roebuck Foundation last year made a grant of $125,000 for the establishment of this Revolving Assistance Fund. The Foundation plans to continue making this grant each year in an effort to be of service to the medical profession in the field of medical distribution. All applications are evaluated by a Medical Advisory Board composed of prominent and highly qualified physicians appointed by the Trustees of the American Medical Association.

In the short time the fund has been in existence, 22 loans have been made to assist 33 physicians from 13 states. The loans ranged in amount from $3,000 to $25,000, and the total reached $179,500. The plan provides for a 10 year, nonsecured loan with the interest ranging from zero to six per cent, depending on the rapidity of payment. General practitioners, specialists, partnerships and medical groups have been the recipients of these loans. The sole criterion, aside from medical proficiency, has been the need of the community for medical care. In order to keep the Revolving Fund growing, all repayments, both principal and interest, go into the fund for future loans. There is no charge to this fund for administration of the program as this expense is met by another Foundation grant.

This notable contribution to better medical care in this country offers a unique opportunity for assistance which will be welcomed by more and more physicians as they become informed of the existence of the fund and how it operates. Certainly this plan has great potential. The future of the Revolving Fund and the rapidity of its growth rest with the physicians who avail themselves of the aid it offers to promote medical care where it is needed most. The Sears- Roebuck Foundation is to be congratulated on this praiseworthy philanthropic endeavor in the realm of medical service.

Southern Medical Association Observes Golden Anniversary

Chattanooga, October 2-3
Washington, November 12-15

The Southern Medical Association, whose membership of some 10,000 embraces 16 states and the District of Columbia, will celebrate its golden anniversary at The Read House in Chattanooga, Tenn., on October 2 and 3, 1956. It is fitting that the celebration should take place at the birthplace of the association, for on these two October dates back in 1906 it was organized in this historic hotel, long famed for its Southern hospitality.

Dr. J. P. Culpepper Jr., of Hattiesburg, Miss., is the chairman of the honorary advisory committee and will preside at the dinner meeting on Tuesday evening, October 2. Dr. Culpepper is president-elect of the association and will take office in November. Dr. W. Raymond McKenzie, of Baltimore, is now serving as president. The immediate past president, Dr. R. L. Sanders, of Memphis, Tenn., will be the principal speaker for the occasion. His 50 years of professional life has run concurrently with the life of the association, and the subject of his address will be "Fifty Years of Medicine in the South." Dr. Dwight H. Murray of Napa, Calif., President of the American Medical Association, will represent the American Medical Association and bring greetings.

The final activity of the celebration will be the unveiling of a bronze plaque at The Read House on Wednesday, October 3. Mr. C. P. Loranz, Advisor and Professional Relations Counselor, formerly Secretary-Manager of the Southern Medical Association for many years, is serving as chairman of the committee in charge of the celebration.

The Southern Medical Association Golden Anniversary Meeting is scheduled for Washing-

ton, D. C., on November 12 to 15. This fiftieth annual meeting is expected to be the most outstanding of all the meetings held in the half century of the association's existence. The Washington meeting has been planned to climax fittingly the 50 year history of "The Southern" in a setting rich in historical, cultural, governmental and scientific attractions. The Medical Society of the District of Columbia is arranging a topflight scientific program for the first day, Monday, November 12, which has been designated "D. C. Day." There will be two large sessions, one in medicine and one in surgery, covering a wide range of timely subjects.

Appropriate ceremonies officially celebrating the fiftieth anniversary will be a major feature of the meeting. With President McKenzie presiding, the history of the Southern's unique contribution to the advancement of medicine during the past half century will be unfolded.

The association's 20 sections will hold 48 full half day sessions on November 13, 14 and 15. These scientific programs, embracing every major field of medicine and surgery, will have broad appeal to the specialist and general physician alike. In addition to the program of his own general practice section, the general practitioner may choose at will from among the nearly 300 papers, panels and symposiums which will be presented in the various sections. The freedom of the specialist and the general practitioner to attend any part of the scientific assembly is a unique feature of the association's meetings.

The geriatrics symposium, initiated at the Houston meeting last year, will be repeated in Washington. Moderated by Dr. Milford D. Rouse, of Dallas, Texas, the symposium will present a full half day program on a variety of medical and surgical problems of the older age group. In keeping with the ever broadening interest in this special field, an impressive list of eminent authorities will participate. The symposium is open to every physician in attendance.

An unusually large number of selected scientific exhibits and a record number of technical exhibits will be on display in the Exhibit Hall, located in the Sheraton-Park Hotel. Among the many other attractions are special reunions of more than 20 alumni and fraternity groups, a program promising "little business, much fun" for the Woman's Auxiliary in the beguiling setting of the nation's capitol, and a special program for women physicians. In addition, several regional specialty group meetings will either immediately precede or follow the Southern's scientific assembly, thus adding to the scientific diversity of the Golden Anniversity Meeting.

Joint Blood Council Action

A nationwide survey of blood banks was one of several important projects undertaken by the Joint Blood Council at its June meeting in Chicago. The survey will be under the direction of Dr. Frank E. Wilson, of Washington, D. C., Executive Vice President of the council. A National Blood Banks Directory, based on the findings of the survey, will be issued. It will contain the following information: location and areas served by individual blood banks and hospitals; how each is operated, organized and supervised; whether commercial or nonprofit; adaptability for expansion in a national emergency; volume of business; and relationship of each blood bank to allied services, such as tissue banks. Included in the directory will be a glossary of terms and definitions used in blood banking and blood research.

The creation of a Bureau of Information also was authorized by the council's board of directors. It will serve as a clearing house on progress being made everywhere in all aspects of blood-banking and blood research. The information will be widely disseminated in blood-banking circles and will be available to others on request.

The establishment of a national diagnostic center or reference library was approved. It will make available information on ways to stimulate the study of unusual serums and red blood cells. In addition, further study will be made of the problem of maintaining national and local blood donor registries for the rarer blood groups.

An ad hoc industry liaison committee was appointed to look into the need of the pharmaceutical industry for more "surplus" blood to keep its blood fractionating facilities in operation. This committee may, at the discretion of the president of the council, be set up as a permanent committee.

Approval was given in principle to recommendations of a temporary committee on blood insurance problems. These were that immediate steps be taken to (1) attempt to persuade health and accident insurance companies to limit their coverage to the cost of voluntary procurement, processing and dispensing, and (2) encourage Blue Cross to include in its coverage the cost of

processing and dispensing, without any form of donor payment or professional fee.

The directors unanimously agreed that there is imperative need that minimal standards for voluntary accreditation of blood banks be decided upon and widely disseminated in professional fields.

Recognition was given to the need for stimulation of research in the following areas: (1) long range storage of the red cells; (2) practical means of platelet preservation; (3) preparation and testing of antihemophilic globulin; (4) the effect on the red cells of water-repelling surfaces; (5) further investigation of anticoagulant procedures such as ion exchange resins to replace citrate in the operation of blood banks, to make possible continuous use of large quantities of blood, as required in some operative procedures; (6) continuance of the work to eliminate as donors possible carriers of S. H. virus, or sterilization of the blood itself; (7) recommendations for ideal transfusion equipment in so far as it affects the quality of the formed elements but not necessarily the safety, already considered by the minimum requirements.

Officers re-elected were: Dr. Leonard W. Larson, President; Dr. James J. Griffitts, Vice President; and Dr. Frank E. Wilson, Vice President and Secretary. Dr. LeRoy E. Bates is the newly elected treasurer. Dr. Griffitts, of Miami, currently president of the American Association of Blood Banks, not only will serve the council as vice president for another year but will also serve on the project advisory committee and act as chairman of the industry liaison committee. The Joint Blood Council was formed last year with five member institutions cooperating, namely, the American Medical Association, the American Association of Blood Banks, the American Hospital Association, the American National Red Cross and the American Society of Clinical Pathologists.

Executive Secretary Honored

Mr. John C. Lee, Executive Secretary of the Dade County Medical Association, recently was elected to the Board of Directors of the Medical Society Executives Conference. He was one of two county medical society representatives added to this body at its meeting in Chicago in June at the time of the 1956 annual meeting of the American Medical Association. The conference is an association of executive personnel of national, regional, state and county medical organizations. This national organization functions as a group prepared to lend assistance to its members when administrative problems are concerned.

The Conference is to be congratulated on the wisdom of its choice in utilizing the services of the genial and highly competent Mr. Lee as one of its directors. His constructive approach to current problems, his wise leadership and his valuable experience will enable him to render excellent service on this national level.

Graduate Medical Education

Florida Clinical Diabetes Association
October 18-19, 1956

The fourth annual meeting of the Florida Clinical Diabetes Association will be held at the Duval Medical Center in Jacksonville on October 18 and 19. During the meeting there will be a seminar on diabetes mellitus with Dr. Samuel B. Beaser of Boston and Dr. Philip K. Bondy, Associate Professor of Medicine, Yale University School of Medicine, New Haven, Conn., as guest speakers. Dr. Beaser will discuss "The Medical Profession's Role in Diabetes Mellitus," "Treatment of Diabetes Mellitus with the Axylsulfonylureas," "Treatment of the Difficult Diabetic," and "Pregnancy and Atherosclerosis in Diabetes." Dr. Bondy's subjects will include "The Mechanism of Diabetes in the Light of Modern Knowledge," "Kidney Diseases in the Diabetic," "Treatment of Diabetic Acidosis," and "The Diagnosis of Diabetes." Among the member speakers are Dr. George H. Garmany of Tallahassee, Dr. Joseph H. St. John of Jacksonville, and Dr. Benjamin L. Brock, Medical Director of the Central Florida Tuberculosis Hospital in Orlando. In addition to the lectures there will be a clinic presentation and panel discussions.

The annual dinner meeting of the group will be held on Thursday evening, October 18, and the public meeting will be presented on Friday evening, October 19, in cooperation with the Diabetes Association of Duval County.

Southeastern States Cancer Seminar
November 7-8, 1956

The Southeastern States Cancer Seminar, which is held biennially, will be presented this year at the Hotel George Washington in Jacksonville on November 7 and 8 under the direction of the Cancer Committee of the Duval County Medical Society, the Florida Medical Association and the Division of Postgraduate Education of the College of Medicine of the University of

Florida, and supported by the American Cancer Society, Florida Division, and the Florida State Board of Health. Among the outstanding members of the faculty and panels are Dr. Alton Ochsner, Dr. Everett D. Sugarbaker, Dr. Elliott Scarborough, Dr. Eugene P. Pendergrass, Dr. Richard B. Cattell and Dr. George T. Pack. No registration fee will be charged, and the course is approved for credit.

Cancer Cytology Congress Chicago, October 9-11, 1956

The First International Cancer Cytology Congress will be held at the Drake Hotel in Chicago on October 9, 10 and 11. Sponsors of the Congress are the American Society of Clinical Pathologists, the College of American Pathologists, the Inter-Society Cytology Council and the International Union Against Cancer.

The comprehensive scientific program contains a series of broad discussions on the practical values of cytology as an effective diagnostic technic. It therefore should be of great interest to practicing physicians of all specialties in which cytology plays a part. On Tuesday morning, October 9, Dr. George N. Papanicolaou of New York will present the first paper, entitled "The Historical Landmark in Exfoliative Cytology." There will follow on Tuesday and Wednesday 22 papers covering many aspects of the subject, to be presented by distinguished authorities in this country and from abroad. On Tuesday afternoon there will be a panel discussion on "Aspiration Biopsy," and on Wednesday two panel discussions, one in the morning on "Problems in Confirming Cellular Evidence of Cancer" and one in the afternoon on "Prognosis in Cancer of the Uterine Cervix as Determined by Histologic and Cytologic Methods."

The Thursday morning session will be devoted to papers on new advances in cytology. The meeting will close on Thursday afternoon with a symposium on "Carcinoma in Situ of the Uterine Cervix."

Copies of the program are available on request to Mr. L. H. Peterson, Executive Vice President, American Cancer Society Florida Division, Inc., 416 Tampa St., Tampa 2, Fla. For specific information concerning the Congress, inquiry should be directed to Dr. Arthur H. Dearing, College of American Pathologists, Prudential Plaza, Suite 2115, Chicago 1, Ill.

University of Miami School of Medicine Graduates First Class

A high moment in the history of medical education in South Florida was reached on June 11, 1956 when the first class was graduated from the University of Miami School of Medicine. In the precommencement and commencement exercises appropriate to this notable occasion, the Dade County Medical Association had a prominent role.

At a pregraduation dinner sponsored by the faculty of the School of Medicine, held at Miami Springs Villas on June 9, the 26 members of the first graduating class were individually honored by the county society. Its president, Dr. Hunter B. Rogers, in recognition of the occasion gave to each graduate a reminder of the peculiar significance of the successful completion of the school's first four years of medical instruction in the form of a personalized certificate.

Also, on this occasion, on behalf of the county medical association Dr. Rogers presented to the School of Medicine an elaborate plaque bearing a soapstone engraving of the Anglicized translation of the Oath of Hippocrates. A brass plate below the engraving bears this inscription, "Presented to the University of Miami School of Medicine in honor of its first graduating class June 11, 1956 by the Dade County Medical Association. Hunter B. Rogers, President, Vincent P. Corso, Secretary." This plaque will be prominently mounted at the medical school as a memento of this first class and all future graduating classes.

On the invitation of Dean Homer F. Marsh of the School of Medicine, Dr. Rogers was privileged to climax the program by administering the Anglicized version of the Hippocratic oath, the Sponsio Academica, to the new physicians in the presence of some 200 members of the association and the other guests attending the dinner.

Scores of members of the association, volunteer members of the Clinical Faculty of the School of Medicine, also participated in the commencement procession, led by the medical school graduates two days later at Dinner Key Auditorium. The 26 graduating seniors represented 13 of Florida's 67 counties. Among them were six from Dade County, who entered the first medical school class on Sept. 22, 1952. Norman Kenyon, from Clearwater in Pinellas County, delivered the "Class Legacy" and announced the establishment of a $200 Endowment Fund by the senior class for the School of Medicine. He also an-

nounced the organization of an alumni group from this first class and on behalf of the class presented a watch to Dean Marsh in appreciation of his leadership.

Upon graduation, 16 of the new physicians expressed a special interest in entering general practice after completing their internships and residencies. All 26 were accepted for internship, beginning this September. Of the group, 14 will intern at three Florida hospitals in Miami, Tampa and Jacksonville and seven at Jackson Memorial Hospital in Miami. The remaining 12 were accepted at nine other hospitals in seven states and the District of Columbia.

Two of the graduates received top awards. One award, the Aesculapius, sponsored by the Beta Xi Chapter of Phi Beta Pi, medical fraternity, went to Frank G. Wilson of Miami, for an outstanding combination of qualities of scholarship, investigative interest, performance of physician-patient relationship and the meaning of medicine to the community. The Arnold J. Lehman Award went to Richard Gerald Alper of Miami Beach, for demonstration of the greatest promise in pharmacology during his four years as a medical student. This annual award was established by Dr. William B. Deichmann, chairman and professor of the Department of Pharmacology of the School of Medicine, and was named for Dr. Arnold J. Lehman, Chief of the Pharmacology Section, United States Food and Drug Administration, who, as the featured speaker at the preconvention dinner, spoke on "Fiftieth Anniversary of the Federal Food and Drug Laws."

All Florida congratulates the University of Miami School of Medicine on being the alma mater of the first 26 physicians ever to receive the degree of Doctor of Medicine from a Florida institution of higher learning. The Florida Medical Association wishes these fledgling physicians Godspeed and a brilliant career in their chosen profession.

Association Executive Receives National Recognition

At the annual meeting of the American Medical Association, held recently in Chicago, Mr. W. Harold Parham, Assistant Managing Director and Supervisor of Public Relations of the Florida Medical Association, was signally honored by the Board of Trustees of the American Medical Association. He was made a member of the Public Relations Advisory Committee to the Board. In this capacity Mr. Parham joins with a small number of other executives from state and county medical societies representing different sections of the nation to act in an advisory capacity to the Trustees of the American Medical Association as they examine new aspects of public relations and re-evaluate existing programs.

This recognition of Mr. Parham's talents and achievements, so well demonstrated both on the public relations and on the legislative level in his labors for the Florida Medical Association, is particularly gratifying to the Association. His wealth of knowledge and broad experience should enable him to render valuable service on a national scale as he fills the new post.

Dade County Medical Association's New Home Under Construction

The ground-breaking ceremony, on June 12, 1956, for the new home of the Dade County Medical Association marked an important milestone of progress in the history of that organization. Now that construction is actually under way, a long-sought goal is in sight, with occupancy scheduled in late November.

The high hopes and persistent efforts of the 20 housing committees serving the association since 1936 are taking tangible form in a unique structure of modernistic design with an interior patio ample in size to allow for future expansion. The present structure provides a home and business office entirely adequate for the needs of today and of the foreseeable future. Located at Southwest Thirteenth Street and Miami Avenue, this first home of its own for the Florida Medical Association's largest component county society will be one of the finest buildings of its type in the country. This association becomes the second county society in Florida to own its home.

The enthusiasm for the project shown by those participating in the ground-breaking ceremony reflected the feelings of the entire membership. Those who took part were Dr. Hunter B. Rogers, President; Dr. Ralph W. Jack, chairman of the Board of Trustees; Dr. Walter W. Sackett Jr., President-Elect; Dr. Milton Coplan, acting chairman of the Housing Committee; Dr. Robert M. Harris, a member of the Housing Committee; Mrs. Robert F. Dickey, President of the Woman's Auxiliary; and Mrs. E. W. Cullipher, Woman's Auxiliary representative to the Housing Committee. The chairman of the Hous-

ing Committee, Dr. J. Raymond Graves, was absent from the city at the time of the groundbreaking event.

The Journal offers hearty congratulations to this great medical society on the realization of a dream that becomes a mighty step forward in its fine record of progress.

University of Florida College of Medicine Accepts First Class

A unique opportunity for professional training confronts the 50 students who will comprise the first class of the College of Medicine of the University of Florida. The class will begin studies with the opening of the 1956-1957 term this month and will graduate in June of 1960.

Dr. George T. Harrell Jr., Dean of the College of Medicine, stated recently that 424 applicants, 240 of them from Florida, had been screened to obtain the 47 students who had been accepted at that time. Of this number, 43 were from Florida and four from out of the state. The remaining three were to be chosen from students completing their work in the state this summer. Approximately three applicants were interviewed for every student accepted. Of the 43 Florida students accepted, seven were from Duval County, six from Dade County, five from Pinellas County, four from Alachua County, three from Broward County, three from Palm Beach County, two from St. Johns County, and one from each of the following counties: Bradford, Charlotte, Citrus, Escambia, Gulf, Hillsborough, Hernando, Marion, Monroe, Nassau, Okaloosa, Polk and Putnam.

In its new program of medical education the University of Florida is undertaking to explore the role of the university in medicine. Unprecedented preliminary research has gone into the broad concept of this approach, projected on a basic philosophy embracing two points of view: (1) the education of the physician in the university setting and (2) the care of patients in the local community. In an article entitled "The University in Medicine: Concept of the New Program at the University of Florida," published in the June 23, 1956, issue of The Journal of the American Medical Association, Dean Harrell describes the program the University is developing. This student-centered program emphasizes the training of the family physician for practice in the local community as a student may expect to find it 10 to 20 years hence. A university-wide theme of human biology is being used, bringing to bear all resources of the university in the exploration of "better methods of education of any person who might be used in a program of patient care in the local community, as well as better methods of patient care."

These fortunate 50 students who will be the first to have the benefit of this practical new curriculum will be educated to become citizens, and their professors within the medical school will have a sufficiently broad background to contribute to this aspect of their development. Their training also will prepare them "to accept responsibility for definitive medical care of the families in their charge and to ease not only the medical but also the sociologic, psychological, and economic impact of disease upon the family." Such a program, with a completely new physical plant admirably designed to implement it, offers them an unprecedented opportunity to pioneer in professional training that augurs well for the future of the medical profession and the health of the citizens of Florida.

Medical Sciences Building University of Florida Dedication, October 12 - 13

The Medical Sciences Building, the first unit of the J. Hillis Miller Health Center at the University of Florida, will be dedicated in Gainesville on October 12 and 13, 1956. The Medical Sciences Building houses the Colleges of Medicine and Nursing. This September the College of Medicine is beginning the instruction of its first class of 50 students.

The program of dedication will begin at 4:00 p.m., October 12, with a Memorial Service to Dr. J. Hillis Miller, the late President of the University. The Medical Sciences Building, as well as the entire Health Center, will be an enduring memorial to Dr. Miller, through whose farsighted vision and energies the Health Center was planned and its creation made possible. A portrait of Dr. Miller will be unveiled and hung in the Medical Sciences Building at this time.

On Friday evening, October 12, at 8:00 p.m. the Health Center will present Dr. Wendell M. Stanley as one of two noteworthy speakers for the occasion. Dr. Stanley, winner of the Nobel

The first unit of the J. Hillis Miller Health Center, the Medical Sciences Building (above), of the University of Florida will be dedicated October 12 and 13. The structure will house the Colleges of Medicine and Nursing. The program, beginning at 4:00 p.m. October 12, will be held in the Auditorium of the new building.

Prize in Chemistry in 1946, is at present a Professor of Biochemistry and Director of the Virus Laboratory at the University of California. He will give a scientific address, entitled "A Look At Viruses Today."

Saturday morning, October 13, at 9:30 a.m., Dr. Detlev W. Bronk, President of the Rockefeller Institute for Medical Research and President of the National Academy of Science, will be presented as guest speaker. Dr. Bronk, eminent in the world of Education as well as Science, will speak on "The University in Medicine."

These programs will be held in the Auditorium of the new Medical Sciences Building. There will be an opportunity before and after each program for all those interested to tour the new building. It is hoped that everyone, professionally or non-professionally attentive to progress in Health Education and Care, will find it possible to be in Gainesville at this time to attend the marking of a new era in the pursuit of Health in the State of Florida.

OTHERS ARE SAYING

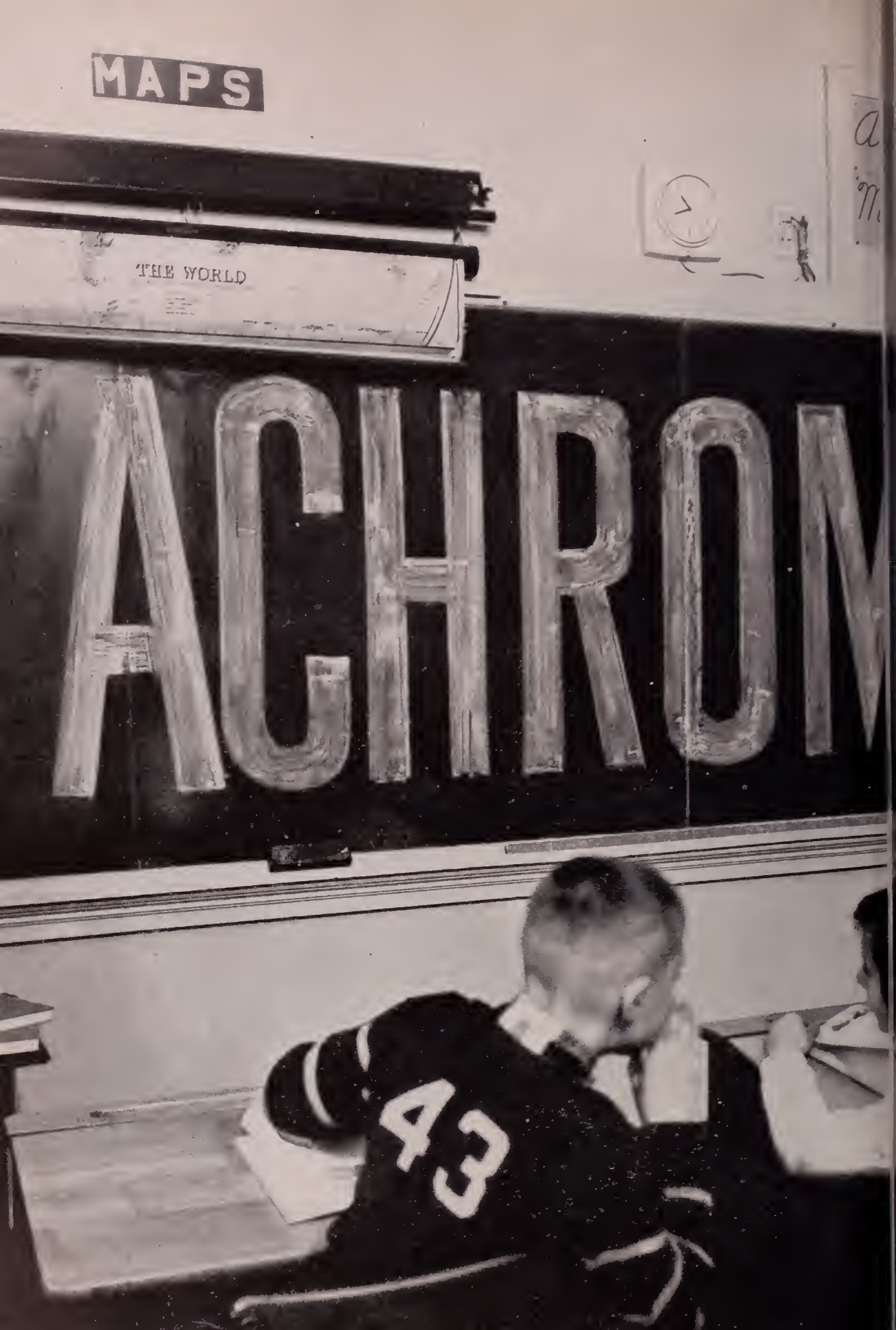
The Medical Rat Race

Only a few decades ago, doctors swore that Fowler's solution was specific for chorea and colchicum was a sovereign remedy for gout. They used to remove gall stones and leave the gall bladder in. Apparently in medicine you have to unlearn as fast as you learn. Nearly every medical maxim is subject to change without notice. The pace is so fast today that if you spent just one year away from medicine, you'd miss many significant changes. On your return you'd be writing prescriptions for remedies that even the pharmacists would consider old-fashioned, and you'd be ignorant of several brand new developments.

To keep up with the dizzy tempo of medical change would really require the doctor's full time. It would take weeks to understand the mode of action of antibiotics and more weeks to know what ACTH was all about. Since he has to practice too, the physician must work out some method of keeping up with medicine without throwing his patients out of the reception room.

In the February 26 (1955) Journal of the American Medical Association, Dr. D. G. Vollan

(Continued on page 274)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ACHROMYCIN*

Tetracycline *Lederle*

in the treatment of

respiratory infections

January and his associates[1] have written on the use of tetracycline (ACHROMYCIN) to treat 118 patients having various infections, most of them respiratory, including acute pharyngitis and tonsillitis, otitis media, sinusitis, acute and chronic bronchitis, asthmatic bronchitis, bronchiectasis, bronchial pneumonia, and lobar pneumonia. Response was judged good or satisfactory in more than 84% of the total cases.

Each month there are more and more reports like this in the literature, documenting the great worth and versatility of ACHROMYCIN. This antibiotic is unsurpassed in range of effectiveness. It provides rapid penetration, prompt control. Side effects, if any, are usually negligible.

No matter what your field or specialty, ACHROMYCIN can be of service to you. For your convenience and the patient's comfort, Lederle offers a *full* line of dosage forms, including

ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection—defends the patient—hastens normal recovery. For severe or prolonged illness. Stress formula as suggested by the National Research Council. Offered in Capsules of 250 mg. and in an Oral Suspension, 125 mg. per 5 cc. teaspoonful.

For more rapid and complete absorption. Offered only by Lederle!

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[1]January, H. L. et al: Clinical experience with tetracycline. *Antibiotics Annual* 1954-55, p. 625.

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(Continued from page 271)

reports on a survey of the physicians' graduate educational technics. He points out that there are five fields for learning: professional contacts, hospital staff meetings, formal graduate courses, medical society meetings, and the primer maker of full men, reading. The doctor puts in anywhere from 15 to 22 per cent of his total professional time on learning. But no physician thinks that this is enough.

Some practitioners have to depend on the detail men to keep them up to date. The detail men have a pitch which is compact, very practical and goes down as smoothly as maple syrup. But no M.D. really thinks that that is the way to keep up to date.

Of course many medical articles are repetitious, many fail to deliver any new ideas, and some are misleading. The trouble is that it takes time even to screen them out. If a doctor has hospital affiliations, he has two or more institutions insisting that he go to monthly staff meetings, plus monthly service meetings, and there sometimes is a real "papa spank" sanction behind the plea. The medical society, the academy, possibly a specialty society also clamors for his time. The medical journals may remain in their wrappers in virginal intactness, for who has time to read journals when so many live societies (and now television instruction) demand the doctor's time? (What *are* you doing reading this item when you ought to be improving your mind at a meeting, conference, seminary, colloquium, or vide-clinic?

So the trend towards abstracts. The journals select the cream of the crop, so every article is an abstract of a massive project. Then there is the summary or conclusion section at the end, an abstract of the abstract. Then there are periodical abstract services plus year books of various sorts which abstract the abstracts of the abstracts.

There ought to be a law. The doctor has to see patients and go to medical society meetings, read journals and read books, attend hospital staff meetings and take an occasional graduate course. He has to listen to detail men, read the wrappers around the samples, study the legends on the free blotters he gets, and fill out forms for Blue Cross, Blue Shield, Workmen's Compensation, Social Security, Veterans Administration, Internal Revenue, Sickness Indemnity Benefits, Life and Casualty Companies. If he doesn't study the books and journals he's an old stick-in-the-mud. If he doesn't fill out the forms he's non-cooperative. If he spends all his time seeing patients, filling out forms and keeping up with the literature, then he remains within the narrow walls of the medical rat race and never enjoys any hobbies, cultural reading, leisure time, music or other amenities. And you know what *that* makes him!

But let's not ask for pity. We probably love it this way.

—*The Journal of the Medical Society of New Jersey, June 1955*

BIRTHS AND DEATHS

Births

Dr. and Mrs. William J. Phelan, of Jacksonville, announce the birth of a daughter, Carolynn Michelle, on July 17, 1956.

Dr. and Mrs. Clyde M. Collins, of Jacksonville, announce the birth of twin sons, Leo Wilkie and Edward Mac Duffie, on June 9, 1956.

Dr. and Mrs. Edward W. Ludwig, of Jacksonville, announce the arrival of a son, Frank Andrew, in their home.

Dr .and Mrs. Norman Jaffee, of Miami, announce the birth of a son, Evan Mitchell, on July 12, 1956.

Dr. and Mrs. Frederick H. Lucas, of Jacksonville, announce the birth of a son, Frank Henry III, on July 20, 1956.

Deaths — Members

Conly, Leonard H., Key West	July 11, 1956
Elliston, Leroy B., Fort Lauderdale	June 18, 1956
McClane, John W., Fernandina Beach	May 2, 1956
McGuire, John J., Pensacola	July 1, 1956
Washburn, Clayton D., Jacksonville	July 17, 1956
Williams, Arthur G. Sr., Lakewood	May 16, 1956

Deaths — Other Doctors

Crozier, Gordon T., Blountstown	June 30, 1956
Harrison, Aleck P., San Antonio, Texas	August 11, 1955
Herbert, Alpha N., Miami	June 21, 1956
Kenneth, Milena A., Miami	June 30, 1956

COMPONENT SOCIETY NOTES

Dade

Dr. Lawrence V. Hastings, of Miami, was principal speaker for the June meeting of the Dade County Medical Association held at the Miami Woman's Club. The title of his address was "Prophylaxis to Protect Your Pocketbook and Reputation."

Lake

The Lake County Medical Society and the Woman's Auxiliary to the Society met at the Elks Club in Leesburg on September 5. Congressman A. S. Herlong Jr. was guest speaker.

Dr. J. Basil Hall, of Tavares, secretary of the Society, issued invitations to members of other county medical societies for the meeting. The affair began with dinner and a fellowship hour early in the evening.

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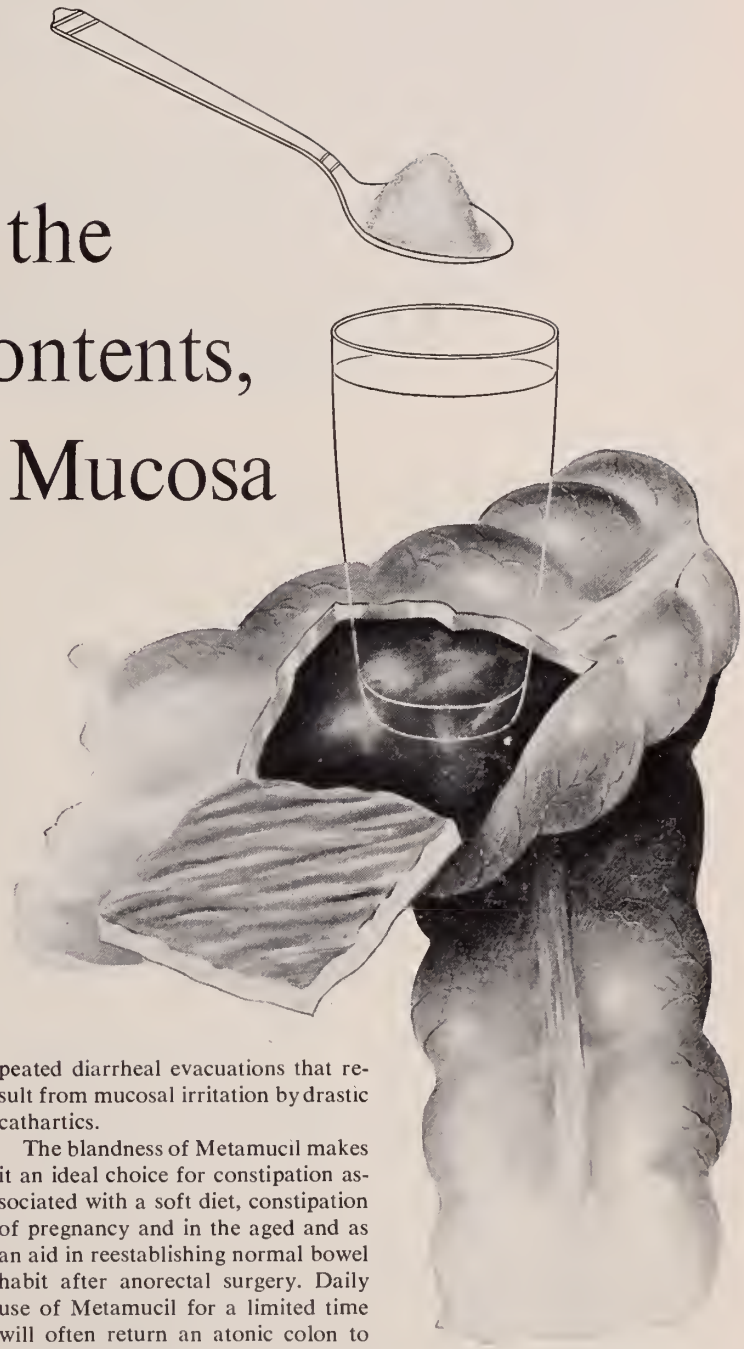

Metamucil is highly refined; it stimulates the bowel musculature, not the mucosa.

When you specify Metamucil in constipation management you are selecting a product which has been made at least 99.6 per cent pure through a complete process of refinement.

All possible irritants (rough parts of the psyllium seed, undesirable oils and similar materials) are discarded during the refining process. A relatively small quantity of purified mucilloid powder is the result. To this is added an equal weight of pure anhydrous dextrose to insure complete dispersion in the colon.

Such meticulous preparation assures that only the bulk-producing mucilloid portion of the psyllium seed remains and that Metamucil will act as a purely "physiologic" constipation corrective, providing bland distention to stimulate the bowel muscularis.

The Metamucil mixture (formed by adding water to Metamucil) elicits gentle colonic reflex peristalsis. Evacuations are normally formed and are not irritating. The bowel stimulation imparted by Metamucil is only sufficient to clear the colon of its contents; patients are not annoyed by the repeated diarrheal evacuations that result from mucosal irritation by drastic cathartics.

The blandness of Metamucil makes it an ideal choice for constipation associated with a soft diet, constipation of pregnancy and in the aged and as an aid in reestablishing normal bowel habit after anorectal surgery. Daily use of Metamucil for a limited time will often return an atonic colon to normal function.

Metamucil® is the highly refined mucilloid of Plantago ovata (50%), a seed of the psyllium group, combined with dextrose (50%) as a dispersing agent. It is supplied in containers of 1 pound—also 4 ounces and 8 ounces.

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WANTED: Physician with Florida license. Interest in Physical Medicine and Geriatrics. State qualifications in writing. The Miami-Battle Creek, Miami Springs, Fla.

GENERAL PRACTITIONER WANTED: Large, spacious office fully equipped with x-ray and laboratory equipment furnished free of charge. Utilities furnished. Strictly private practice. Large winter tourist trade. Good year round population. Write, wire or call Wiley Crews, Vice President, Boca Grande Health Clinic, Inc., Boca Grande, Fla. Phones 2781-4561.

GENERAL PRACTITIONER: Wanted for group practice in Dade-Broward area. Write 69-194, P.O. Box 1018, Jacksonville, Fla.

FOR RENT: In St. Petersburg, downtown offices facing waterfront park and yacht harbor. $1200 year. Apartment available in same building. Contact Mrs. N. H. Henry, 224 Beach Drive, N. E., St. Petersburg.

UROLOGIST: Seeks association with group or other urologist or location for private practice. Board eligible, veteran, Florida licensed. Write 69-198, P.O. Box 2411, Jacksonville, Fla.

WANTED: General Practitioner or Internist to fill vacancy in South Central Florida. Unusual opportunity to get quickly established without great expense. Write for appointment or interview. Write 69-197. P.O. Box 1411, Jacksonville, Fla.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bailey, William J., Naples
Bolls, George F., Lake Butler
Bolton, Alexander A. Jr., Pompano Beach
Brill, Thomas M., Gainesville
Calderin, Victor O., Miami
Cohn, Jess V., Hollywood
Ehlert, Albert J., Miami
Failla, John A., Daytona Beach
Farrell, John J., Miami
Garland, John C., Naples
Hutson, Thomas W. Jr., Miami
Jaffe, Edward B., North Miami Beach
Langley, Daniel B., Naples
Lubrano, Daniel Jr., Fort Myers
Peck, Sidney J., Hollywood
Pullias, George M. Jr., Coral Gables
Russin, Lester A., Miami Beach
Silvers, Louis D., Miami

STATE NEWS ITEMS

Drs. Karl B. Hanson and F. Gordon King of Jacksonville were principal speakers at the quarterly meeting of the Diabetes Association of Duval County held recently at Jacksonville. Dr. Hanson explained the general aspects of diabetic care, and Dr. King discussed "Surgical Diseases and the Diabetic."

Dr. Marion W. Hester of Lakeland has been installed as president of the Polk County Eye, Ear, Nose and Throat Society. Elected to serve with Dr. Hester are Drs. William M. Kummer, president-elect; Spencer Garrett, vice president; Wylie L. Tillis, second vice president, and Harry Halden. secretary-treasurer. The physicians are from Lakeland.

Dr. John S. Williams of Dade City has returned from New Orleans where he did postgraduate work at the Tulane University School of Medicine.

Dr. Ben J. Sheppard of Coral Gables has been appointed health director for North Bay Village.

Dr. Samuel Gertman of Miami has returned from Ann Arbor, Mich., where he attended the Ninth Annual Conference on Aging at the University of Michigan.

Dr. Irby H. Black of Live Oak attended the Southeastern Medical Seminar held the last of July at Saluda, N. C.

Dr. Donald W. Smith of Miami has been elected president of the New Grand Bahama Flying Club.

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relieves pain

improves function

resolves inflammation

BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for literature before prescribing it.

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Dr. Philip J. Chastain of Coral Gables has been elected president of the Miami Pediatric Association.

Dr. Francis C. Hoare of Clearwater and Dr. James C. Fleming of Dunedin discussed blood typing and its uses at a recent meeting of the Clearwater Lions Club.

Dr. Thomas M. Palmer of Jacksonville attended the meeting of the International Congress of Pediatrics held in Copenhagen and visited clinics in various cities before returning from a trip abroad in August.

Drs. William H. Brooks, Robert J. Brown and Jerome H. Newman of Jacksonville attended the recent annual meeting of the American Urological Association held in Boston.

Dr. Eugene L. Jewett of Orlando has been honored for his work on behalf of the physically handicapped in Orange County. He has been awarded a merit citation by the Orange County Chamber of Commerce.

Dr. Rowland E. Wood of St. Petersburg has been honored by the Middlesex North District Medical Society, Lowell, Mass. A paper by Dr. Wood, entitled "Regimentation from Chicago," was published as a guest editorial in a recent issue of the Society's bulletin.

Dr. James J. Griffitts of Miami has been reelected vice president of the Joint Blood Council. In addition to his duties as vice president, Dr. Griffitts will also serve the Council as a member of the Project Advisory Committee and as chairman of the Industry Liaison Committee.

The Commission on Nutrition of The Medical Society of the State of Pennsylvania is making available a new revised edition of its "Manual of Standard Therapeutic Diets." Supplies of the first edition, issued several years ago, have been exhausted.

More than 30 separate diets are presented in the Manual. These cover a wide variety of nutrition needs from liquid diets through soft diets to various types of modified diets. Recommended daily dietary allowances are given as well as a

(Continued on page 282)

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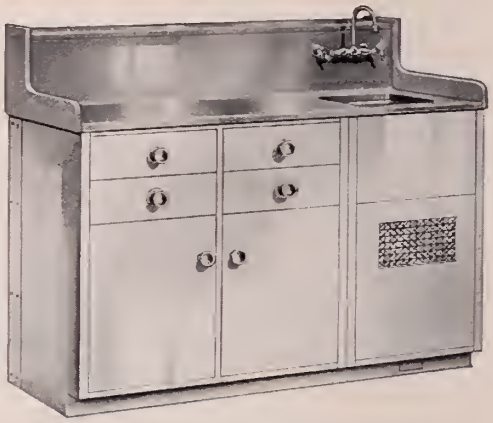

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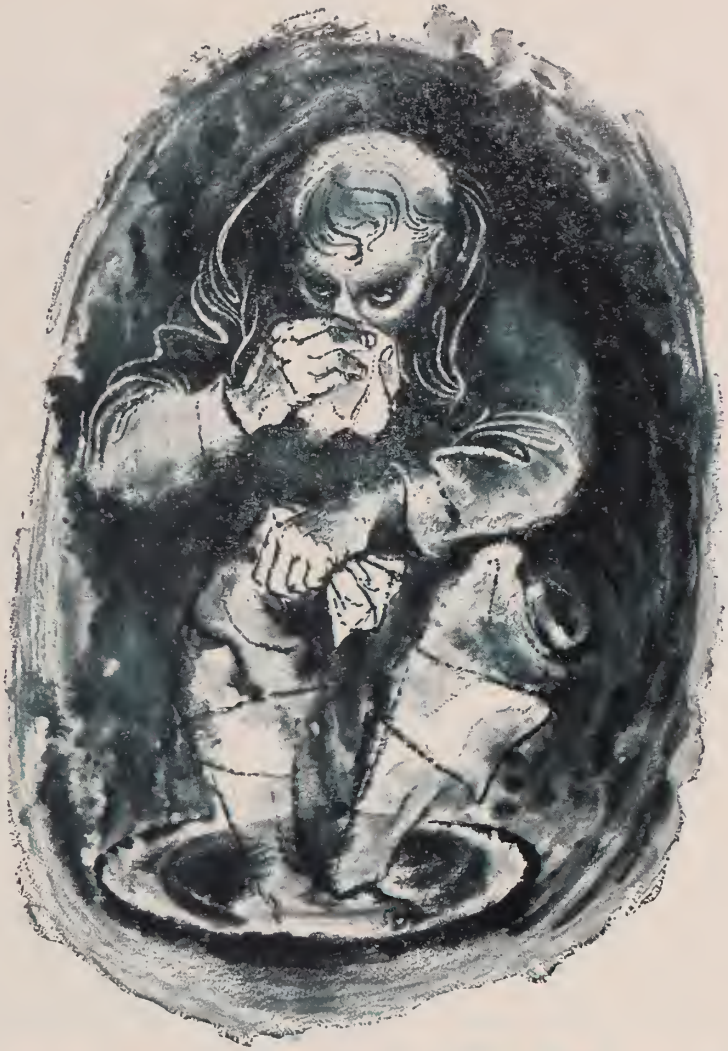

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Bottle of 24 tablets.

Average adult dose: 2 tablets, 4 times daily

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(Continued from page 278)

food composition table for a short method of dietary analysis.

Copies of the Manual may be obtained by sending $1.00 to The Commission on Nutrition, 230 State Street, Harrisburg, Penn.

Dr. Frank Chambers Jr. of Plant City has returned from Saluda, N. C., where he attended a pediatric seminar at the hospital there.

Dr. Ralph Herz of Key West has been visiting hospitals and clinics in New York City and Rochester, Minn.

Dr. Earl S. Davis of Naples was honored recently with a testimonial meeting held in the auditorium of the high school there. More than 500 friends of Dr. Davis gathered for the occasion. As a token of their appreciation for his service to the community, the townspeople presented him with a watch.

Dr. Arthur L. Hardie Jr. of Jacksonville has been elected secretary of the Atlantic Coast Line Railroad Surgeons' Association. Dr. Hardie was chosen during the recent meeting of the group in Jacksonville. One of the principal speakers on the program was Dr. James A. Cousar, also of Jacksonville. Dr. Thomas H. Bates of Lake City. a past president of the Association, served as general chairman of the meeting.

Dr. Leroy H. Oetjen of Leesburg attended the recent meeting in Jacksonville of the Atlantic Coast Line Railroad Surgeons' Association.

Dr. Sidney Davidson of Lake Worth has returned from Chicago where he attended the meeting of the American Diabetes Association as a representative of the Florida Clinical Diabetes Association. Dr. Davidson is governor for the state of Florida for the national association.

Dr. Hubert W. Coleman of Avon Park attended the Yale University Summer School of Alcohol Studies. He was awarded a scholarship by the Florida Alcholic Rehabilitation Program.

Drs. Courtland D. Whitaker and Henry I. Langston of Marianna have been appointed to the Medical Advisory Board of the Jackson County Chapter of the National Foundation for Infantile Paralysis.

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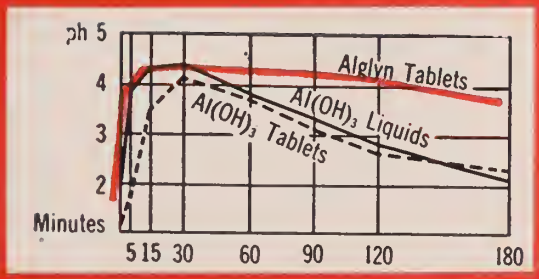

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> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

Also supplied in combination with spasmolytic and sedative therapy as **Malglyn Compound,** each tablet contains dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., phenobarbital, 16.2 mg., per tablet, bottles of 100 (pink); and as **Belglyn,** dihydroxy aluminum aminoacetate, 0.5 Gm., belladonna alkaloids, 0.162 mg., per tablet, bottles of 100 (yellow).

Reprint of recent *in vivo* studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

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Dr. Millard P. Quillian of Bradenton has been installed as president of the Bradenton Rotary Club for 1956-57.

Dr. I. Leo Fishbein of Miami Beach has been visiting clinics and hospitals in Paris, France, and other cities abroad.

Dr. Turner Z. Cason of Jacksonville has been lected president of the Duval District Heart Association. His selection took place during the recent annual meeting held in the city.

The Fall Meeting of the Southeastern Allergy Association has been scheduled for October 5-6 in the Barringer Hotel, Charlotte, N. C. On the program as scientific speakers are Dr. Carl E. Arbesman, President of the American Academy of Allergy, and Dr. Ethan Allan Brown, President of the American College of Allergists. There will also be panel discussions of "Pediatric Allergy" and "Chronic Lung Diseases in Chronic Asthma."

The program has been accepted for credit by the American Academy of General Practice. Information may be obtained from Dr. Katharine B. MacInnis, 1515 Bull St., Columbia, S. C.

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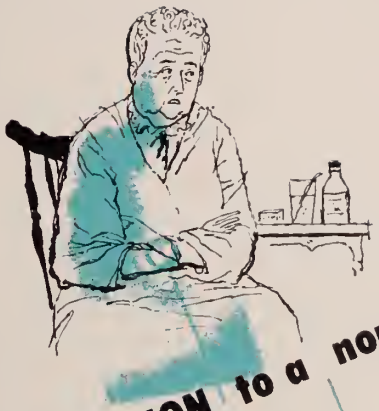

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1. *Levy, S.* J.A.M.A. *153:1260, 1953*
2. *Thompson, Lloyd & Proctor, Rich* N. C. State, *Dec. 54*
3. *Thompson & Proctor,* Clinical Med *April, 1956*

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Erythromycin in the treatment of osteomyelitis

8/3/55

CASE SUMMARY

On 6/2/55, patient, male, age 28, fell on an old fracture and refractured the middle third of the right femur, superimposed on an old osteomyelitis.

On 7/7/55, the wound was saucerized and a hemolytic S. aureus (coag. +) was isolated from the osteomyelitis. Disc sensitivities were: penicillin, 10 units; erythromycin, 10 mcg.; tetracycline, 10 mcg.

On 7/15, the patient was placed on erythromycin therapy 400 mgm. q. 6. h. Patient afebrile after erythromycin started. X-rays showed evidence of healing with callus formation. No septicemia and clinical evidence indicates control of the infection.

On 8/3, the cast was removed and leg recast. Wound was in good condition with minimal drainage.

Diagnosis: fracture middle third of right femur, complicated by osteomyelitis.

Result: erythromycin aided healing of the old osteomyelitis and kept the infection under control.

* *Communication to Abbott Laboratories*

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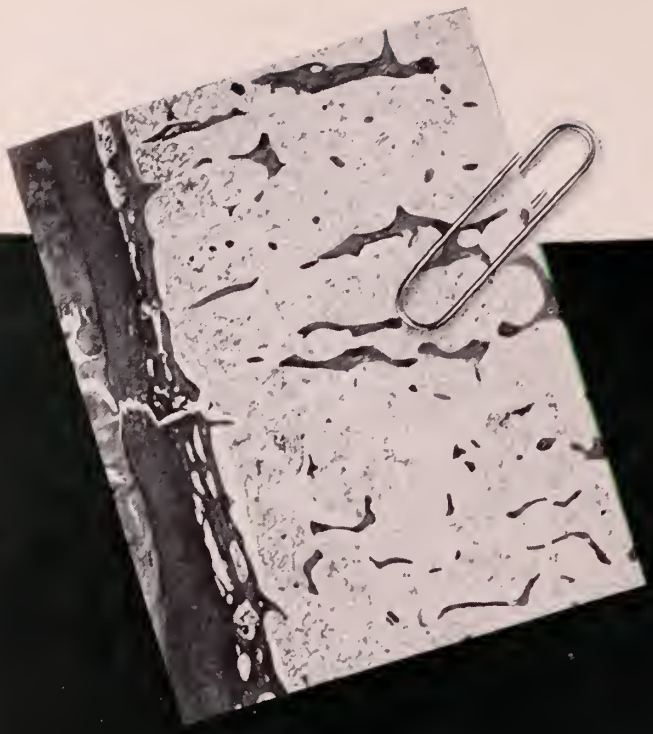

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*Reifenstein, E. C., Jr., and Albright, F.: J. Clin. Investigation *26*:24, 1947.

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Feeding Directions

Baker's Modified Milk (Liquid)

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	Baker's	Boiled Water
Hospital	1 part	2 parts
First week at home	1 part	1½ parts
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Also available in powder form. Normal dilution one tablespoon to 2 ounces of water provides 20 calories per fluid ounce.

Designed for all infant feeding from birth to the end of the first year, Baker's Modified Milk is a time-saver for busy physicians and busy hospitals.

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*Moyer, J. H., and others: J. Chronic Dis. 2:670, 1955.

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OBITUARIES

Frederick Carter Keisling

Dr. Frederick Carter Keisling of Jacksonville died on May 18, 1956. He was 72 years of age.

Born in Brownstown, Ill., on Dec. 6, 1883, Dr. Keisling received his medical training in Missouri. He was graduated from the St. Louis College of Physicians and Surgeons in 1906. He first engaged in the general practice of medicine in Lebanon, Ill. In 1914 he was licensed to practice medicine in Florida and located in Sebring. He moved to Jacksonville in 1918 and practiced there for 38 years.

Locally, Dr. Keisling was a Thirty-Second Degree Mason, a Shriner, a past Patron of the Eastern Star and an Odd Fellow. He was a member of the Methodist Church.

A life member of the Duval County Medical Society, Dr. Keisling held membership in the Florida Medical Association for more than three decades. He was also a member of the American Medical Association and the Southern Medical Association.

Surviving are the widow, Mrs. Frances Wells Keisling, and two sons, Charles C. Keisling and Frederick C. Keisling, all of Jacksonville; one daughter, Mrs. R. L. Garner, of Ann Arbor, Mich.; and eight grandchildren.

Benjamin Franklin Hodsdon

Dr. Benjamin Franklin Hodsdon of Jacksonville died in a local hospital on May 29, 1956, following a heart attack. He was 90 years of age. Interment took place in Berwick, Maine.

A native of Maine, Dr. Hodsdon was born at Berwick in 1865 and took great pride in his New England heritage. He worked his way through college and was graduated in 1897 from Bowdoin, Longfellow's alma mater, then in turn from the New York Polyclinic, the Chicago Eye, Ear, Nose and Throat College, and, in 1908, the University of Illinois College of Medicine. He also studied in France, and frequently during the summers he engaged in postgraduate study.

In 1910, Dr. Hodsdon was licensed to practice in Florida and in 1911 came to Miami from Manchester, Maine, seeking relief from asthma. He remained to practice there for 30 years and became that city's first eye, ear, nose and throat

(Continued on page 296)

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AS THE OTHER TWO LARGEST-SELLING FILTER BRANDS
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Meat...

and Its Place in the Diet in Congestive Cardiac Failure

Meat has an appropriate place in the moderate-protein, low-sodium, acid-ash diet advocated in the dietary management of patients with congestive cardiac failure.[1] When extreme sodium restriction is necessary, the meat allowance is regulated accordingly.

Lean meat allows maintenance of a positive nitrogen balance without excessive protein intake, because its amino acids match the quantity and proportions needed for tissue synthesis and repair.[2,3] In the fresh state as purchased it supplies only small amounts of sodium ranging from approximately 50 to 100 mg. per 100 grams. Due to its acid-ash composition (equivalent to 4 to 38 ml. of normal acid per 100 grams of meat) it may facilitate diuresis.[1]

In addition to these important features, meat contributes valuable nutritional factors by virtue of its generous supply of high quality protein, B vitamins, and essential minerals—iron, phosphorus, potassium, and magnesium.

Easy digestibility, a prime requisite of foods eaten by the patient with congestive cardiac failure, is another outstanding quality of meat.

---

1. Odel, H. M.: Nutrition in Cardiovascular Disease, in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Dietotherapy, Philadelphia, Lea & Febiger, 1955, p. 709.
2. Berg, C. P.: Utilization of Protein, J. Agr. & Food Chem. *3*:575 (July) 1955.
3. Best, C. H., and Taylor, N. B.: The Physiological Basis of Medical Practice, ed. 6, Baltimore, Williams & Wilkins, 1955, p. 638.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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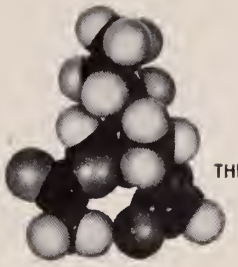

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*Bonica, J.J.; and Backup, P.H.: Northwest Med., 54:22, Jan. 1955.

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(Continued from page 290)

specialist. For 25 years he was a member of the Dade County Board of Health and for a number of years was the local eye, ear, nose and throat surgeon for the Florida East Coast Railroad. He and the late Dr. James M. Jackson selected the site of the present Jackson Memorial Hospital. Locally he was a Mason and a Shriner affiliated with Mahi Temple, a Rotarian, Elk and Odd Fellow, and a member of the Central Baptist Church. In 1940, he moved to Tallahassee, where he resided for five years before coming to Jacksonville to make his home. In Jacksonville, he held membership in the First Baptist Church.

Dr. Hodsdon was twice president of the Dade County Medical Association. He was a life member of the Florida Medical Association holding honorary status since his retirement; he had been a member for 44 years. He also held membership in the Vermont State Medical Society and the New Hampshire Medical Society. In 1950 he received from the New Hampshire Medical Society a gold medal for 50 years of membership. He was also a member of the American Medical Association and the American Academy of Ophthalmology and Oto-Laryngology.

Survivors include a daughter, Mrs. Bryan Page, of Miami, and two grandchildren.

organomercurial diuretics "...permit ingestion of enough salt to make food palatable; without them, many patients would lose their appetites, a consequence of the salt-free diet which has occasionally been known to cause serious malnutrition."*

*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

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Resolutions .....*Lakeland*
MRS. PERRY D. MELVIN, Rev. & Resolutions
Southern Med. Aux. .....*Miami*
MRS. LEFFIE M. CARLTON JR., Doctor's Day.....*Tampo*
MRS. EDWARD W. CULLIPHER,
Jane Todd Crawford Fund.....*Miami*
MRS. LINUS W. HEWIT, Research and Romance....*Tampo*
MRS. ERNEST R. BOURKARD, Student Loan.....*Tampo*
MRS. WILLARD E. MANRY JR., Today's Health.*Lake Wales*
MRS. JOHN R. BROWNING, Yearbook.....*Jacksanville*

Auxiliary Tidbits Including Todays Health

The final figures on *Todays Health* for the credits obtained by auxiliaries have just been sent me by Mr. Robert Enlow, Director of Circulation, *Todays Health,* American Medical Association, Chicago.

For the fifth consecutive year, the Florida Auxiliary went over 100 per cent of its quota and continues to be one of the outstanding states in working on *Todays Health,* but because our membership has grown and because of the work being done by other states to head us off, Florida did not take any prizes this year, for the first time in that five year period. The Florida record follows: STATE QUOTA: 1731. State credits obtained 2310½. Percentage of quota made: 133. By our county auxiliaries, our record looks like this and is one of which we can well be proud:

	Quota	Credits	Percentage of Quota
Alachua (Gilchrist, Union, Bradford)	34	31 8/12	93
Bay	18	40	222

ORAL PENICILLIN FOR *BETTER* AND *MORE CONSISTENT* ABSORPTION

"Because of the better and more consistent absorption of penicillin V from the intestinal tract, it would appear that this type of penicillin is preferable to penicillin G when oral administration is to be used."[1]

1. Martin, W. J., et al.: J.A.M.A. *160*:928 (March 17) 1956.

PEN•VEE•*Oral* and PEN•VEE *Suspension* permit new dependability in oral-penicillin therapy—dependable stability in gastric acid, dependable and optimal absorption in the duodenum. "Not being destroyed by acid in the stomach, as is penicillin G, penicillin V remains available in larger amounts for absorption."[1]

PEN·VEE* *Oral* and *Suspension*

PEN•VEE•*Oral* is Penicillin V, Crystalline (Phenoxymethyl Penicillin)
PEN•VEE *Suspension* is Benzathine Penicillin V Oral Suspension

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Philadelphia 1, Pa

Brevard	24	41 8/12	174
Broward	95	130 4/12	137
Dade	386	642 9/12	167
Duval (Clay)	220	271 8/12	124
Escambia (Santa Rosa)	79	144 8/12	184
Hillsborough	154	102	66
Jackson-Calhoun	11	12	109
Lake (Sumter)	18	20	111
Lee-Charlotte-Collier Hendry	19	12	63
Leon-Gadsden-Liberty-Wakulla-Jefferson	48	100	210
Manatee	26	1 4/12	5
Marion (Levy)	20	6	30
Orange (Osceola)	134	177	132
Palm Beach	95	184	200
Pinellas	124	151	123
Polk	57	55 8/12	95
St Johns (Flagler)	18	41	228
St. Lucie-Okeechobee-Martin	13	21	163
Sarasota	32	33 4/12	104
Seminole	15	36	240
Volusia	59	38 4/12	65
State at large	40	16 8/12	42
Total	1731	2310 1/12	133

This record shows that 16 of the 23 county auxiliaries in Florida went over 100 per cent of their quota — a record which we think is outstanding and one we need not be ashamed of.

However, with the number of doctors who are members of our Florida Medical Association nearing the 3000 mark, we know that the auxiliary could do more than 200 per cent of its quota every year if every doctor would subscribe, as he should, to *Todays Health* and have it available for his patients in his waiting room. Those who do subscribe and who do have it available for patients can well testify to the good it does.

Mrs. Scottie J. Wilson and Mrs. Perry D. Melvin, President and President-elect of the Florida Auxiliary, have been having conferences and making plans for the fall conference of state chairmen, county presidents and presidents-elect which will be held this year, in Fort Lauderdale, Oct. 10 and 11. Details on the place of this conference which is held in conjunction with the fall board meeting and details on the program for the conference will be sent to the county presidents, presidents-elect, state chairmen and state officers in the near future. This will be one of the "don't miss" meetings of the year. Many worthwhile matters are scheduled to be discussed.

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Maintaining Lean Body Mass in the Edentulous Geriatric Patient

Extensive loss of body protein can occur in either the spare or obese geriatric patient. But whatever the patient's somatotype, a decrease in lean body mass is usually the result of inadequate protein intake due to poor dentition, slowed-down digestion and quite frequently, unappetizing main dishes.

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Specific suggestions on how to use Knox Gelatine in different types of geriatric diets are described in the booklets listed in the coupon below.

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Indicate number of special diet booklets desired for your patients opposite title:

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- Conductive Shoes for surgical and operating room personnel. N.B.F.U. specifications.
- We are also the manufacturer of the Gear-Action Shoe designed by noted orthopedic surgeon.
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Comfortable Convenient
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Terms Reasonable

The four vice-presidents, Mrs. Augustine S. Weekley, District C, chairman of the organization committee; Mrs. Bernard M. Barrett, District A; Mrs. Lee Rogers Jr., District B, and Mrs. Willard Fitzgerald, District D, are beginning their plans for the district workshop meetings to be held in conjunction with the district meetings of the Florida Medical Association. Mrs. Barrett will preside at the workshop in District A, Tallahassee, Oct. 30; Mrs. Rogers at the workshop in District B, Ocala, Oct. 31; Mrs. Weekley at the one in District C, Tampa, Nov. 1, and Mrs. Fitzgerald at the workshop in District D, West Palm Beach on Nov. 2. Mrs. Scottie J. Wilson, President of the Florida Auxiliary, is planning to attend all four of the workshop meetings of which further details will be in the mail at a near future date.

Mrs. Scottie J. Wilson, Mrs. Perry D. Melvin, and Mrs. Richard F. Stover, constitutional secretary of the Woman's Auxiliary to the American Medical Medical Association, will attend the fall conference for state presidents and presidents-elect with national chairmen to be held at the Drake Hotel on Oct. 1 and 2. This conference will provide much good information and inspiration for them to pass on to the Florida auxiliary members.

From letters received from around the state, from discussions in person and telephone conversations, it looks as if Florida will have her usual goodly crowd of doctors and their wives on hand at the Fiftieth Anniversary Meeting of the Southern Medical Association in Washington, D. C. from Nov. 12 through Nov. 15. Mrs. Perry D. Melvin is counselor from Florida for the Southern Auxiliary and Dr. Joe Stewart of Dade County is the counselor to the Southern Medical Association from Florida. Having reached the half century mark, many special events are

(Continued on page 304)

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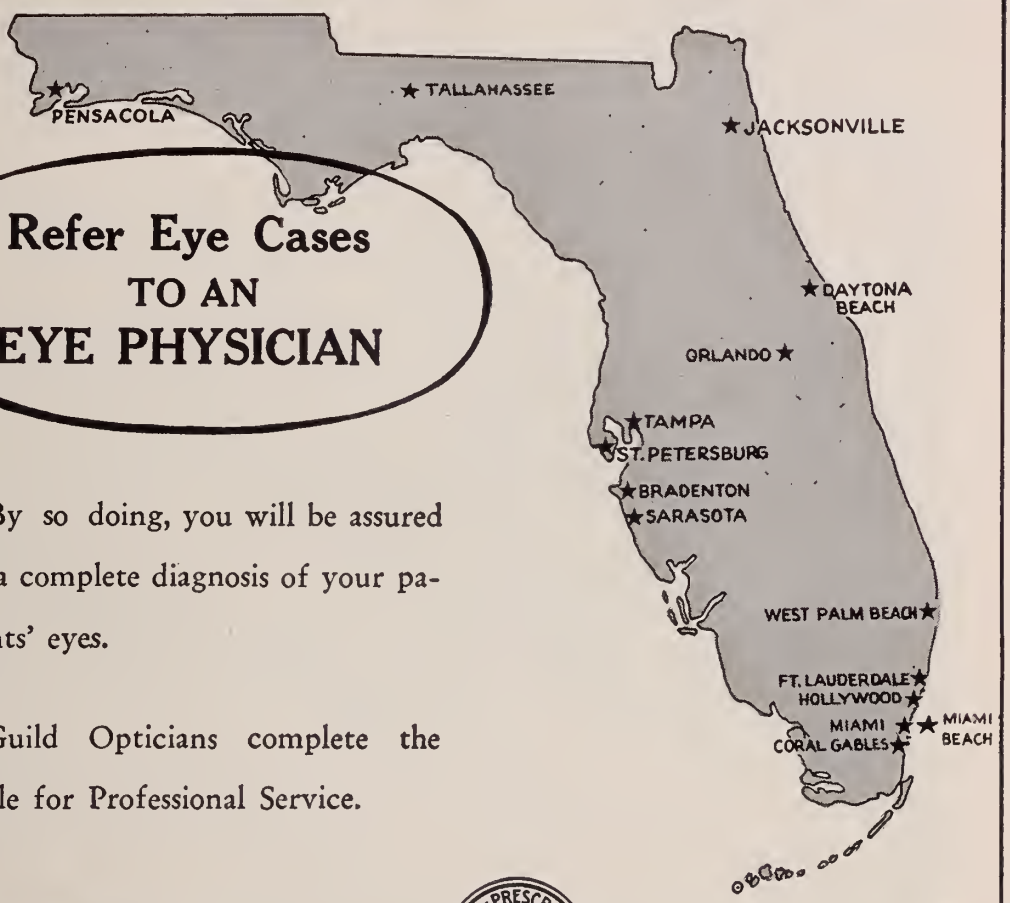

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	Walter C. Hagelgans	712 Seybold Bldg.
	T. S. Budd	122 S. E. First St.
	Harry H. Marsh	401 Langford Bldg.
Miami Beach	Louis Gillingham	630 Lincoln Rd.
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Orlando	Burt J. Rutledge	392 N. Orange Ave.
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St. Petersburg	K. M. Dowdy	322 Central Ave.
Daytona Beach	Harvey E. White	220 S. Beach St.
Pensacola	Bennie Barberl	18 W. Garden St.
Fort Lauderdale	Ray Goodwill	22 E. Las Olas Blvd.
Fort Pierce	William Franklin	196 N. 4th St.
Sarasota	Oscar Loewe	Main St.
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clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of the "predni-steroids" antacids should be routinely co-administered to minimize gastric distress

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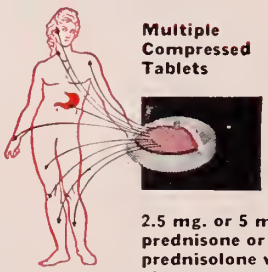

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'Co-Deltra'
(Prednisone Buffered)

All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

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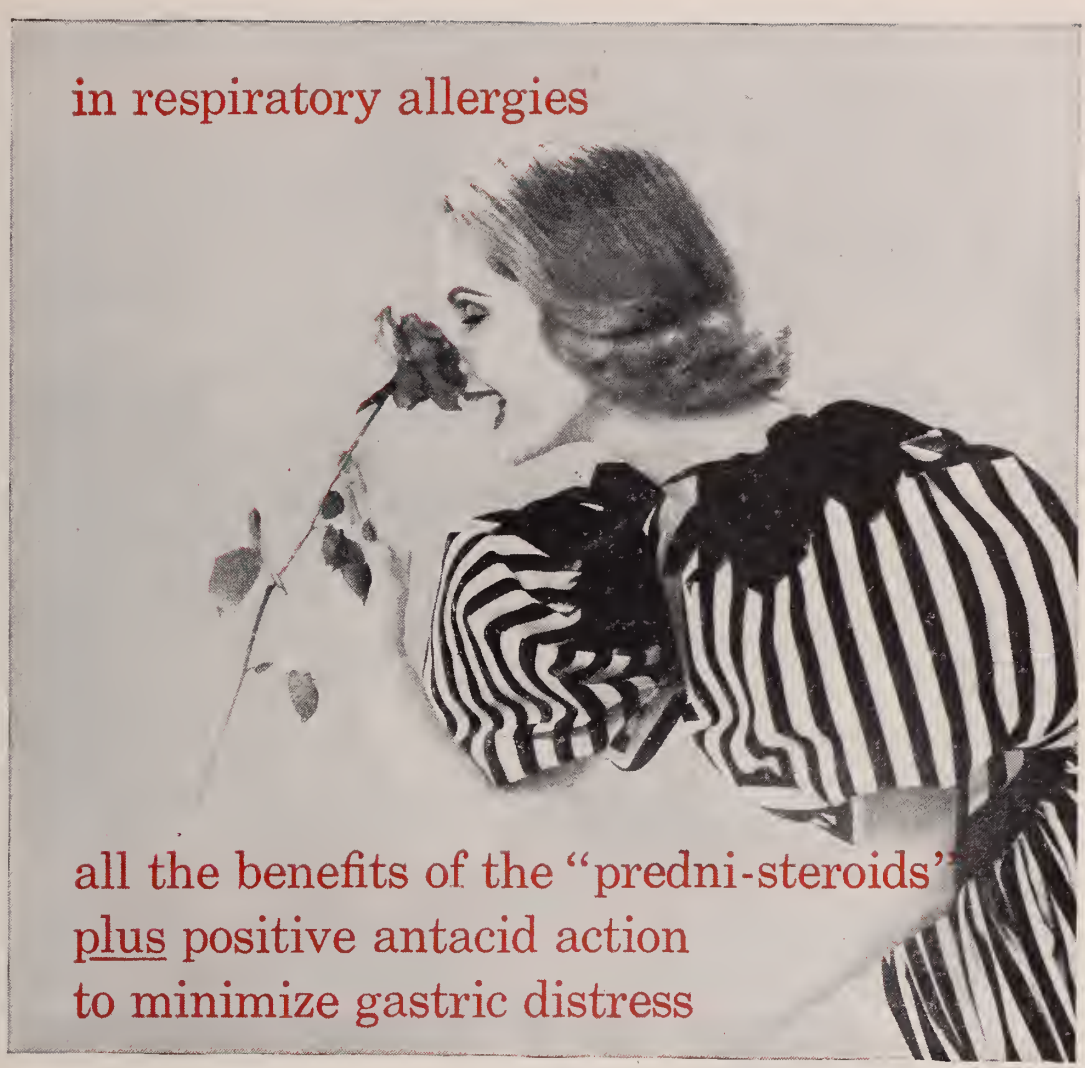

all the benefits of the "predni-steroids"
plus positive antacid action
to minimize gastric distress

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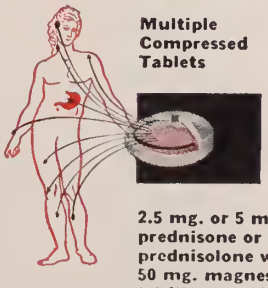

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(Continued from page 300)

planned for this meeting of Southern and the Floridians who attend will not in any way be disappointed. Headquarters for the medical association will be the Sheraton Park and for the auxiliary, the Mayflower Hotel.

At the fall conference for state presidents, presidents-elect and national chairmen, Mrs. Scottie J. Wilson has been selected to speak on the panel on legislation. Mrs. Stover will appear on the panel for officers of auxiliaries.

Programs and plans for the county auxiliaries are now under way for the fall and winter and we can look forward to some big things in Florida this year.

Mrs. Richard F. Stover

BOOKS RECEIVED

Polio Pioneers, *The Story of the Fight Against Polio.* By Dorothy and Philip Sterling. Pp. 128. Price, $2.75. Garden City, N. Y., Doubleday & Company, Inc., 1955.

This book for juniors is the story of all the things that had to be discovered about disease and vaccination and viruses before Dr. Jonas E. Salk, in 1952, could "cook" a very special kind of recipe. He used polio virus instead of eggs and flour to make a vaccine, not a cake or a pie, which was going to save lives. Before he could do so, however, a Dutchman named Leeuwenhoek had to make a microscope; a Frenchman named Pasteur had to study microbes; an Englishman named Jenner had to invent vaccination; and an American named Enders had to find a way to grow polio virus in bottles.

Here is the story of all the people who helped in the fight against polio: a boy in Egypt who had polio 3,500 years ago; James Phipps, the boy who tested Dr. Jenner's smallpox vaccination just as boys and girls today helped test the Salk vaccine; Franklin D. Roosevelt, who founded Warm Springs and the March of Dimes; doctors, scientists, technicians. To read the story is to know what polio is, what causes it, and what will prevent and someday cure the disease. Too, knowing the story will make many a child doubly proud to be a polio pioneer.

Planning Florida's Health Leadership: Medical Education in the University. Edited by Louis J. Maloof. Vol. 5. Pp. 161. Price, $1.50. Gainesville, University of Florida Press, 1955.

This fifth and last volume of the Medical Center Study Series sponsored at the University of Florida by the Commonwealth Fund provides a résumé of University programs related to medical education, research, and service. Three general questions asked of each department participating in the preparation of this volume were: (1) What does your department offer that should be useful to medical education, medical research, or medical care? (2) What does a College of Medicine offer which will be useful to your department? (3) Have you any suggestions regarding methods of integration or information interchange which will affect all parties having these mutual interests?

Chapter 1 explains the term "Health Center," gives the background for establishing medical education at the University, and reviews state needs which make integration necessary — the well rounded education of the family physician, beginning at the University College level. The data pertaining to the departments in the University's Upper Division are given in Chapters 2, 3, and 4. Chapter 5 groups together graduate work, research, and

(Continued on page 308)

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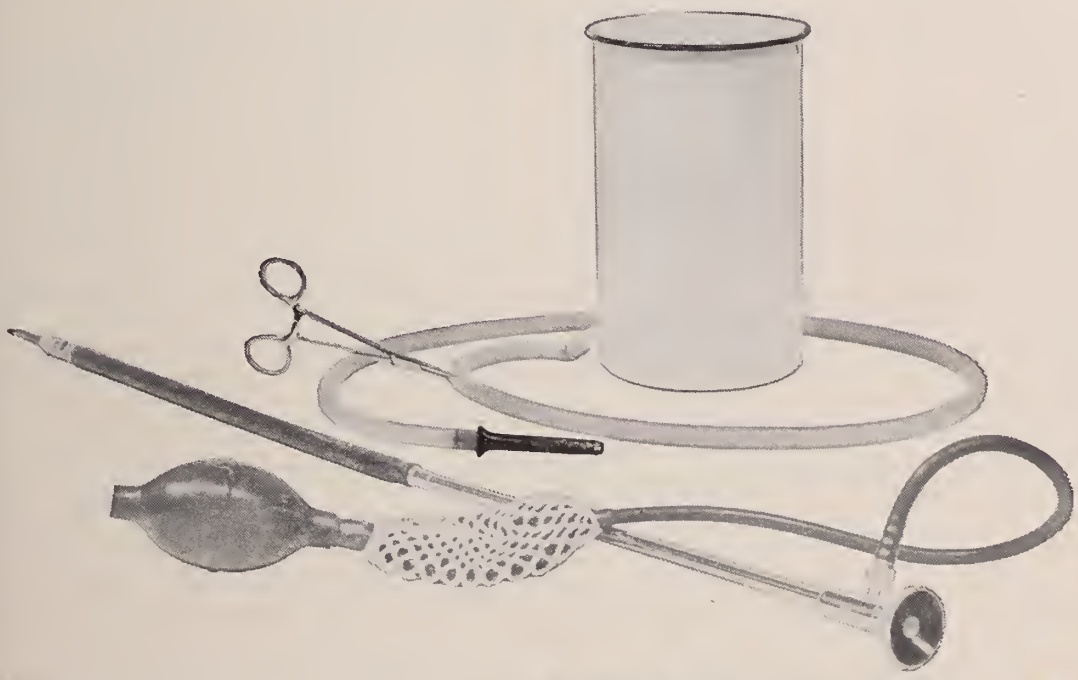

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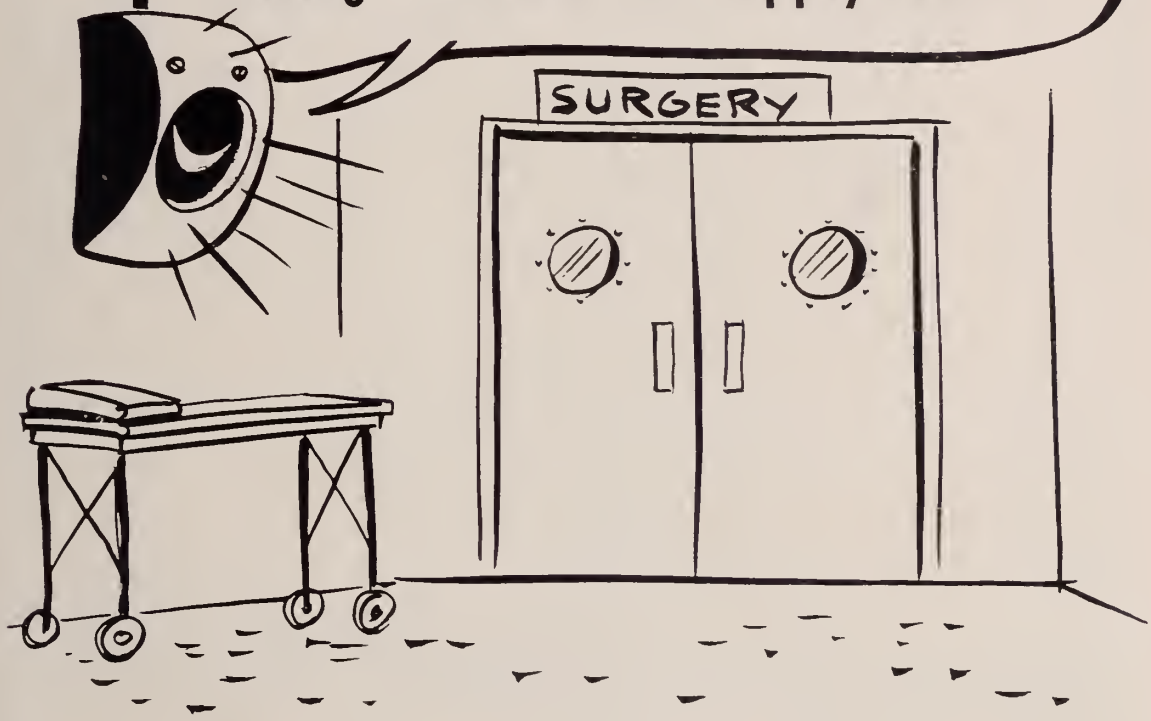

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(Continued from page 304)

service. Chapter 6 presents an excellent example of interdepartmental cooperation in the Florida Center of Clinical Services. Chapter 7 groups the Health Center colleges, the Student Health Department infirmary, and closely related subjects. Chapter 8 presents viewpoints on medical education — the historical trend which has led it to the University campus, together with a proposed integrated plan to liberalize the medical student's curriculum.

The Truth About Cancer. By Charles S. Cameron, M.D. Pp. 268. Price, $4.95. Englewood Cliffs, N. J., Prentice-Hall, Inc., 1956.

Here is a definitive book on cancer which physicians will want to read and recommend to their patients. "Thoughtful reading of this book," says Dr. Elmer Hess, President of the American Medical Association, "can double your chances of avoiding death from cancer. I can imagine no book calculated to yield more important dividends in life and health than this one."

Sanely optimistic, this unique book by the Medical and Scientific Director of the American Cancer Society represents cancer as twice as curable as the present rates of cure show and offers many more heartening facts about this disease. Interpreting as it does the results of more than 150 million dollars' worth of cancer research money spent over the last 15 years, it is full of invaluable advice. It presents everything of practical usefulness for detecting cancer early, promotes understanding of the nature, causes, diagnoses, and treatment of all the varieties of cancer and invites confidence by showing the great strides research has taken. Set forth simply and in an enlightening manner are the latest, authoritative medical facts.

Special features are a clarification of the smoking controversy, the newest material on cervical cancer, now more than 70 per cent curable, a section on why quacks can never cure cancer, a section on cancer in children, and authoritative pictures showing the very first signs of cancerous growth. Emphasizing that ignorance is more deadly than cancer itself, offering practical methods of early detection for some types of the disease, and stressing the major role of the individual in influencing the outcome, this book can help save many lives.

Fifth Annual Report on Stress 1955-56. Edited by Hans Selye, M.D., Ph.D., D.Sc. (Hon.), F.R.S. (Canada), F.I.C.S. (Hon.), and Gunnar Heuser, M.D. (Cologne). Pp. 816. Price, $20.00. New York, MD Publications, Inc., 1956.

This volume represents the fifth of a series of annual supplements to the book entitled "Stress—The Physiology and Pathology of Exposure to Stress" by the senior author, published in 1950. These reports serve as guides to the entire literature on stress and help to correlate all pertinent facts. The rapidity with which this field continues to develop makes this service invaluable.

Within the comparatively short span of the last 19 years the stress concept has taken shape. During this period, and particularly during the last six years since ACTH and glucocorticoids have become generally available, almost every physician has found it necessary to familiarize himself with some facet of this subject. The entire series offers a classified guide system to approximately 30,000 references on stress, the adaptation syndrome, and the adaptive hormones. The scope of these reviews covers, in addition to stress research, such cognate subjects as, for example, the bioassay of corticoids, the metabolism of adrenaline, drugs affecting neoplastic growth, inflammation (in connection with local stress) or hypertension (viewed as a "disease of adaptation")

In seeking the two major aims of information and integration, this report is written, as were the earlier reports, as a combination of an extensive, classified index of new facts, with a concise evaluation of the principal data. It also includes nine special reviews on selected, timely subjects.

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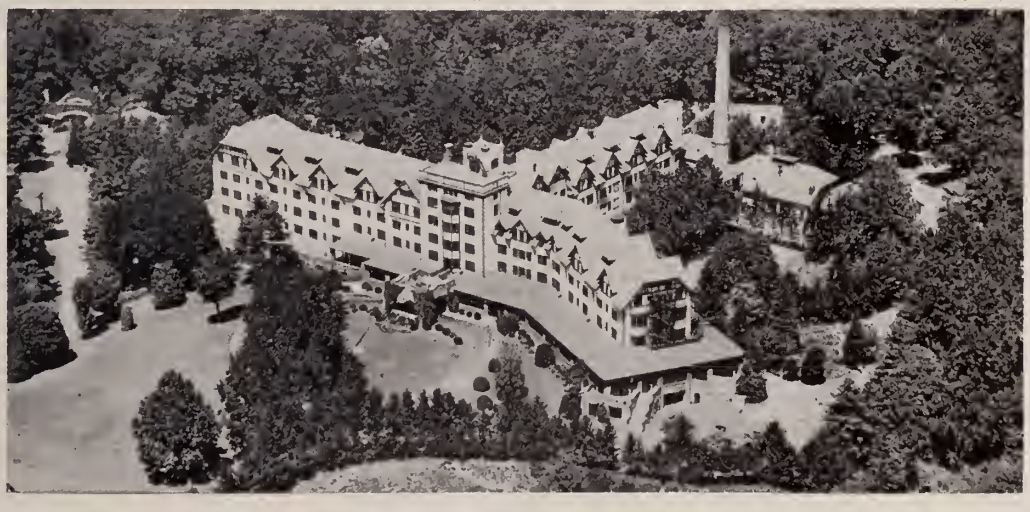

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JOHN D. MILTON, M.D., Secy., 1955.....Miami

County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Albert G. Love IV, Gainesville	G. Leonard Emmel, Gainesville	2nd Tues.	59
**Bradford, Gilchrist, Union*				
Bay	Joseph H. Morris, Panama City	John J. Hollomon Jr., Panama City	1st Tues.	30
Brevard	Isabel Roberts, Melbourne	Jack T. Bechtel, Eau Gallie	2nd Tues.	42
Broward	Thomas F. Huey Jr., Fort Lauderdale	Anthony C. Galluccio, Hollywood	4th Tues.	143
Columbia	Thomas H. Bates, Lake City	Clifton G. York, Lake City	1st Mon.	11
**Baker*				
Dade	Hunter B. Rogers, Miami	Vincent P. Corso, Miami	1st Tues.	768
DeSoto-Hardee-Highlands-Glades	Merle C. Kayton, Wauchula	Roland W. Banks, Wauchula	1st Tues.	27
Duval	Joseph J. Lowenthal, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	316
**Clay*				
Escambia	Gretchen V. Squires, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	104
**Santa Rosa*				
Franklin-Gulf	Harold B. Canning, Wewahitchka	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	James N. Patterson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	203
Indian River	Vernon L. Fromang, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	10
Jackson-Calhoun	Richard H. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	18
Lake	Geoffrey H. Binneveld, Leesburg	J. Basil Hall, Tavares	1st Wed.	34
**Sumter*				
Lee-Charlotte-Collier-Hendry	Joseph L. Selden Jr., Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	46
Leon-Gadsden-Liberty-Wakulla-Jefferson	Robert H. Mickler, Tallahassee	Odis G. Kendrick Jr., Tallahassee	Quarterly	71
Madison	Candler K. Hayes, Madison	Wilmer J. Coggins, Madison		8
Manatee	Richard V. Meaney, Bradenton	Eugene E. Biel, Bradenton	2nd Tues.	29
Marion	William J. McGovern, Ocala	Robert L. Gibson, Ocala	3rd Tues.	32
**Levy*				
Monroe	Allen Shepard, Key West	William R. Ploss, Key West	1st Thurs.	13
Nassau			Last Fri.	9
Orange	Thomas C. Butt, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	201
**Osceola*				
Palm Beach	Walter R. Newbern, West Palm Beach	Horace D. Atkinson, West Palm Beach	4th Mon.	151
Pasco-Hernando-Citrus	Gail M. Osterhout, Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Daniel F. H. Murphey, St. Petersburg	Whitman C. McConnell, St. Petersburg	1st Mon.	249
Polk	James T. Shelden, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	111
Putnam	Bennie J. Massey, Palatka	Bernard E. Kane, Crescent City	2nd Tues.	10
St. Johns	Reuben J. Plant Jr., St. Augustine	Roy E. Campbell, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Alfred J. Cornille, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	26
Sarasota	Eugene D. Liddy Jr., Sarasota	Karl R. Rolls, Sarasota	2nd Tues.	64
Seminole	William V. Roberts, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	Shirley L. Hadden, Live Oak	Hiram B. Curry, Jasper	1st. Sat.	12
**Hamilton, Lafayette*				
Taylor	Ralph J. Greene, Perry	John H. Parker Jr., Perry	Last Fri.	5
**Dixie*				
Volusia	Theodore F. Hahn Jr., DeLand	Achille A. Monaco, Daytona Beach	2nd Tues.	89
**Flagler*				
Walton-Okaloosa	Henry C. White Jr., Fort Walton Bch.	George W. Barrow Jr., Crestview	3rd Tues.	21
Washington-Holmes	Martin L. Lane, Chipley	L. H. Paul, Bonifay		4
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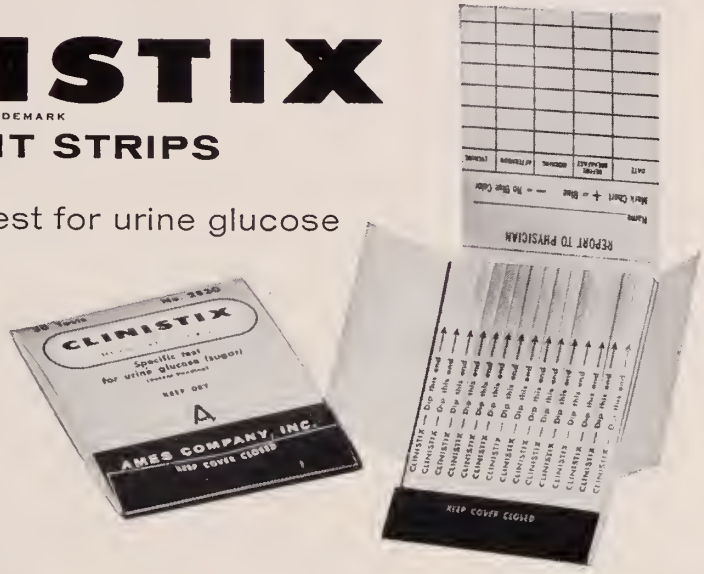

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1. Wikler: The Use of Chlorpromazine as an Anti-emetic in Children, Arch. Pediat. *72*:197 (June) 1955.
2. Daeschner et al.: Chlorpromazine in the Control of Vomiting in Children, Am. J. Dis. Child. *89*:525 (May) 1955.
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5. Moyer et al.: Clinical Studies of an Anti-emetic Agent, Chlorpromazine, Am. J. M. Sc. *228*:174 (Aug.) 1954.

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Vol. XLIII OCTOBER, 1956 No. 4

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James E. Kicklighter and Melvin M. Simmons

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PROGRAM ON PAGE 364

MSD

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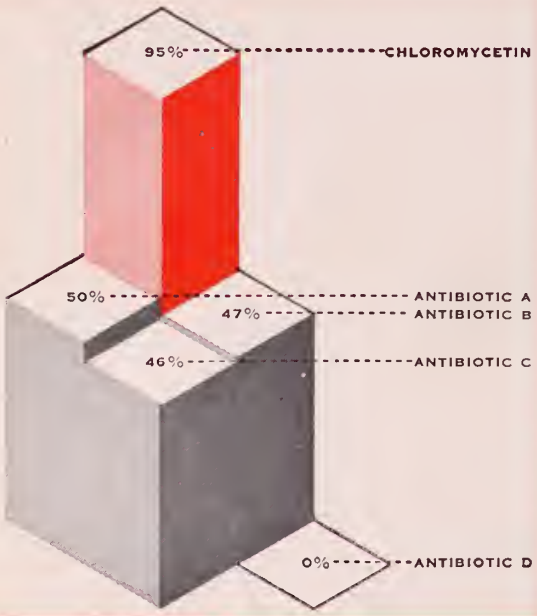
SENSITIVITY OF COMMON PATHOGENS TO CHLOROMYCETIN AND FOUR OTHER MAJOR ANTIBIOTIC AGENTS



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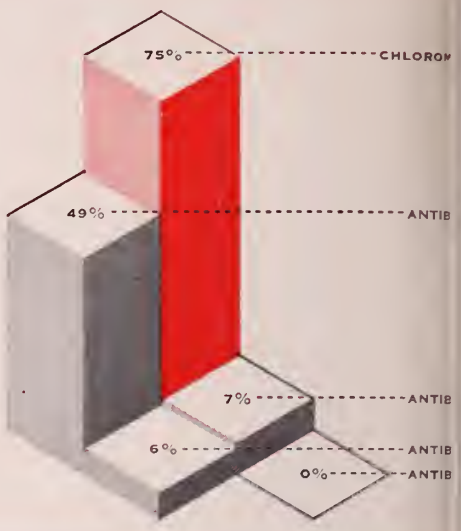

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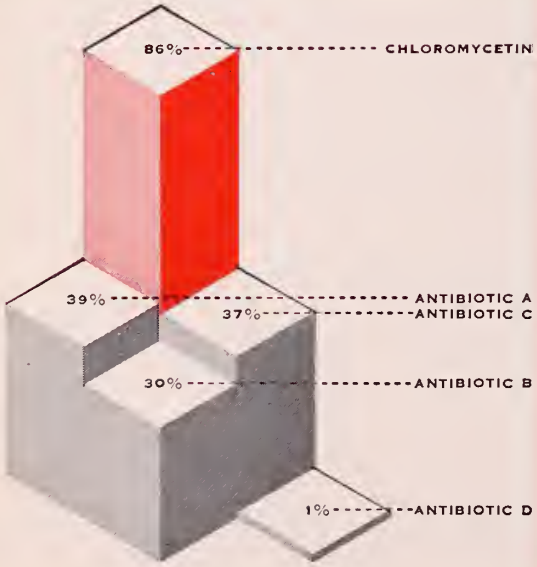

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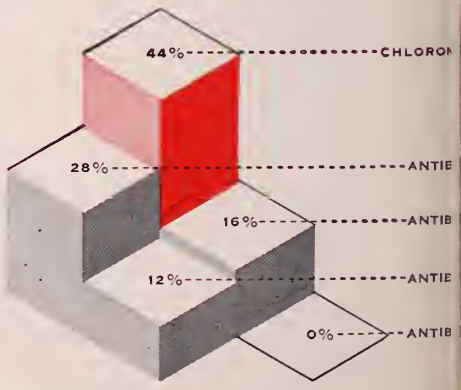

*This graph, based on *in vitro*
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References: (1) Felix, N. S.: *Pediat. Clin. North America* 3:317, 1956. (2) Joron, G. E.; Fowler, A. F.; de Vries, J.; Reid, G., & Mathews, W. H.: *Canad. M. A. J.* 73:956, 1955. (3) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (4) Perry, R. E., Jr.: *North Carolina M. J.* 16:567, 1955. (5) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (6) Murphy, F. D., & Waisbren, B. A., in Murphy, F. D.: Medical Emergencies: Diagnosis and Treatment, ed. 5, Philadelphia, F. A. Davis Company, 1955, p. 557. (7) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305, 1955. (8) Horton, B. F., & Knight, V.: *J. Tennessee M. A.* 48:367, 1955.

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2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

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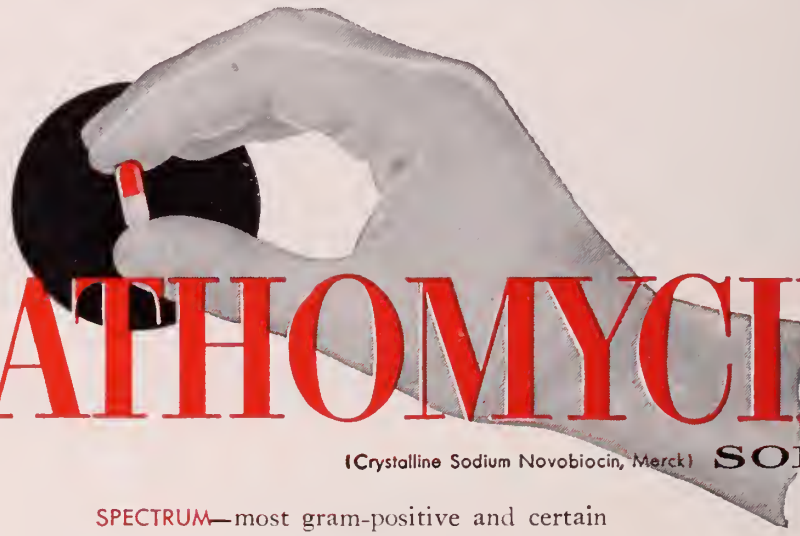

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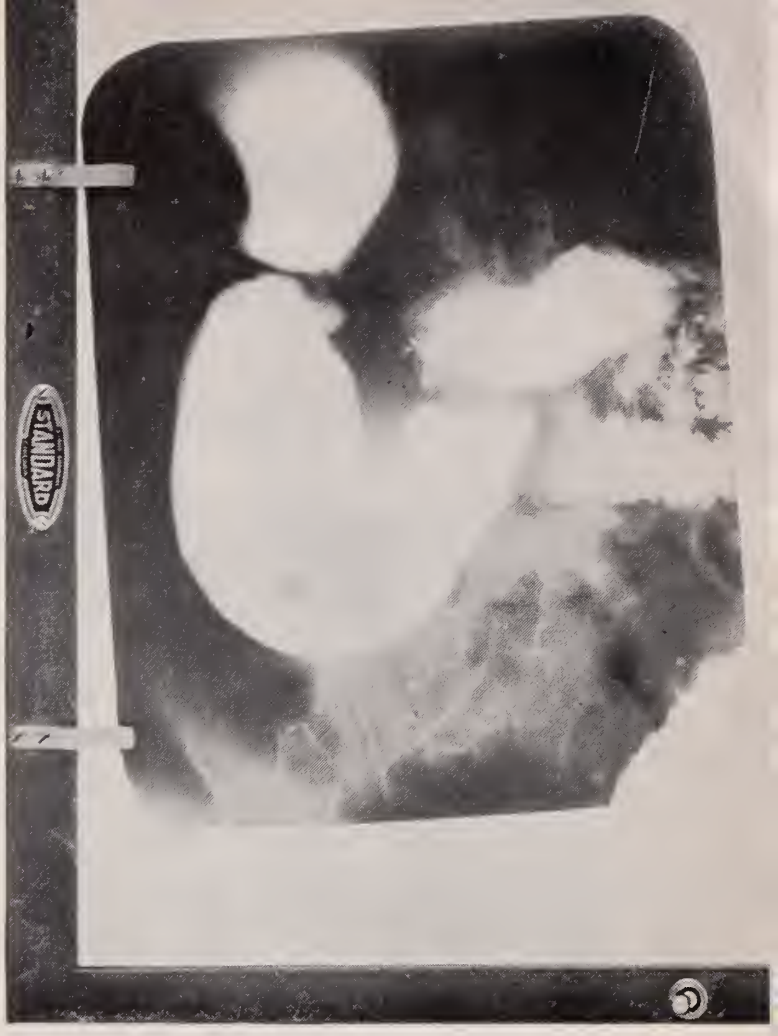

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2. Lemere, F.: Northwest Med. *54*:1098 (Oct.) 1955.

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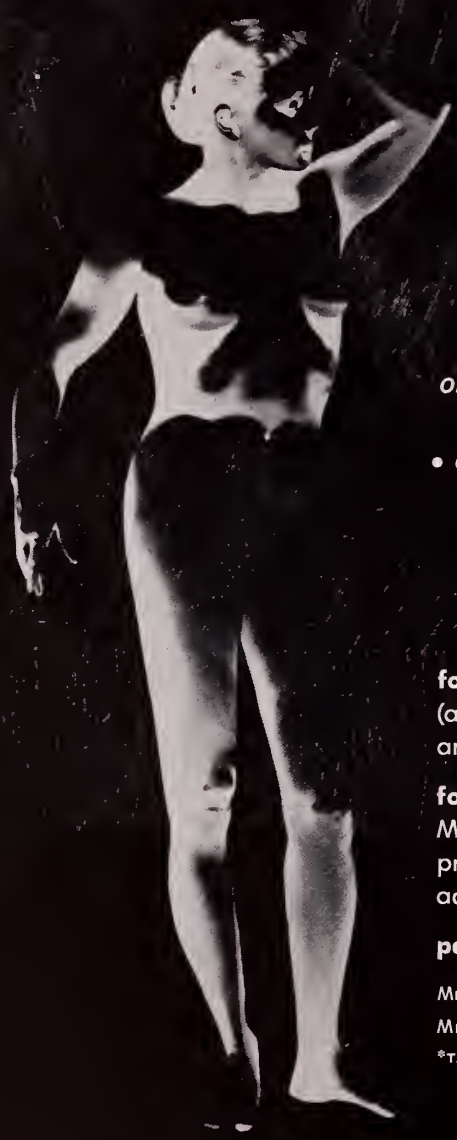

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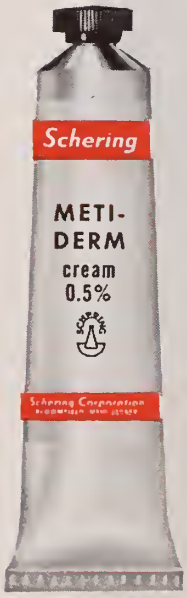

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Therapeutic Application of Ultrasound Energy

Results of Broad Clinical Survey

KENNETH PHILLIPS, M.D., MIAMI
ROBERT R. HARRISS, M.D., HOLLYWOOD
LEIGH F. ROBINSON, M.D., FORT LAUDERDALE
AND
EDWARD F. CARTER SR., M.D., TAMPA

Field trials, covering 10 years in Europe and five years in the United States, have definitely established ultrasound energy as a valuable therapeutic agent. The clearcut clinical value is no longer in doubt by those experienced in its usage; but since it represents a new type of physical agent, this energy has brought with its evolution problems involving controversy, ambiguity, and even frustration, to some attempting its practical application.

There are now established sufficient clinical fundamentals to clarify most of these smoke screens, and to assemble clinical data, from which the general physician can orient himself. Since he uses physical agents only as adjuncts in therapy, he can hardly be expected to find time for exploring the multitude of articles written by the specialists. He needs a compendium at his reference table covering practical facts from which he can calculate his own conclusions.

The objective of this compiled report is primarily concerned with this need. The assembly has been purposely delayed awaiting the end results of multiple testing and control patterns by individual investigators at separate locations.

Ultrasound Compared to Other Established Physical Energies

World War I initiated, and World War II elevated, the physical energies to a therapeutic level whereby they are now used in all branches of the healing art. The older and established agents are universally familiar, but ultrasonic waves are not. They represent a different fundamental from the other physical energies.

The physiologic impact of the older energies may be conveniently classified into one of four groups: Thermal, Chemical, Electrical, and Radiation. Ultrasonic energy obeys none of them specifically, and for this reason, we term it a new physical agent. Not only is this true in the therapeutic sense, but also industrially. Its use in dishwashing, diamond and quartz cutting, fragmenting proteins and minerals, cracking boiler scale and curing of tobacco and whisky are only a few examples currently before the public in headlines.[1] Physicians, therefore, are called upon by the public for intelligent answers.

By comparison, the impact of ultrasonic energy may be visualized as follows: (1) It is not specifically thermal, except that no energy exists without some association of heat. Some workers refer to it as a "cold wave" since it will vaporize water, but the steam is cold. (2) The energy is not primarily chemical, although it seems to act as a catalyst to biochemical reactions in intracellular exchange and dialysis.[2-4] (3) It is not electrical since the energy emitting from the transducer (soundhead) is mechanical; and (4) it is not truly radiation (even though it can be beamed) in the sense of roentgen rays or radium, because it does not strike at the nuclear structures of cells, and in therapeutic dosage, does not destroy tissue.

Biologic Action and Clinical Indications

From the clinical viewpoint, the following established major actions of ultrasonic energy, together with the suggested therapeutic application of each, can be enumerated: (1) It is a decongestive agent, and is superior, in both time

Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami Beach, May 14, 1956.

and effect, to previous modalities in certain acute conditions. Acute sprains of ankles, wrists, and back respond dramatically to proper application. Acute bursitis of the shoulder, especially if followed with intermittent cryotherapy during the first 24 hours, responds equally well. Zach, Haeusler and Lindgren[5] have shown the muscular relaxant effects. (2) Ultrasound energy can be beamed, and, therefore, "target action" is obtained. The other conventional energies, such as shortwave and radar, do not lend themselves to this application. At the same time there exists a selectivity at different tissue interfaces to ultrasonic energy, so that deep penetration can be obtained without sidechain insult to adjoining tissue structures. For example, the deeper structures can be reached without excess heating of superficial skin or fat, but they cannot be reached in this way with diathermy or infrared. These characteristics lend ultrasound therapy to the more chronic conditions of arthritis, bursitis, functional back distress, whiplash syndrome and fibromyositis. Our experience, however, indicates that the acute conditions are more responsive than the chronic (table 1).

Improved therapy for the low back distress syndrome is still sought by clinicians. Ultrasonic is a valuable agent in these functional back upsets. The intervertebral disk syndrome is becoming better understood, and currently receiving great emphasis. Recent articles by Naylor, Happey and MacRae[6] and Cole and Wilson[7] are most instructive in this connection. Van Went,[3] Zach and his associates[5] and others have studied the effects of ultrasonic therapy in this condition, and their evidence points to a hope that this nonsurgical adjunct will prove valuable (table 1).

Clinicians will desire a résumé of relevant scientific fundamentals which underlie the application of ultrasound, but detailed coverage would be beyond the scope of this paper. Zach and his associates,[5] in an article soon to be published, have covered this objective extensively. They have permitted us to review the galley proofs and comment thereon. By extensive and controlled experiments, they have established the physiologic action of ultrasonic energy at both local and general (systemic) levels.

We have already discussed the local action; but the physiology at a systemic level is more intensive. The Zach group have indeed shown a reflex action involving not only the skin, viscera and central nervous system, but specificity of action upon the autonomic chain with its subsequent effectiveness toward enzyme and hormonal function. These findings bring ultrasonic energy into the focus of the entire "stress" phenomena.

Ultrasound in Diagnosis

Space will permit only a mention in this connection.[8-11] Howry and his associates[8,9] and others[10,11] have published details relative to the

Table 1. — Combined Tabulation (All Authors) Showing Total Cases Treated with Results Obtained in Some Common Disorders

Clinical Grouping	Total Cases	Age Range	Sex		Duration		Results (Results Refer to Relief of Symptoms)		
			M	F	Acute	Chronic	None	Moderate	Good
Pain and distress syndromes									
Acute bursitis (shoulder, scapula)	1,806	25-81	1,204	602	All		46	504	1,256
Chronic bursitis (shoulder, scapula)	1,003	31-86	711	292		All	134	482	387
Acute sprains and contusions (ankle, knee, wrist and shoulder)	2,877	14-67	Mixed		All		228	411	2,238
Post fracture pain—ribs	210	27-51	Mixed			All	25	63	147
Limbs after splints removed	156	7-72	109	47		All	10	16	130
Neuralgias (sciatic, post dental extractions, herpes zoster)	980	31-54	Mixed		323	657	492	292	196
Low back syndrome (strains, functional distress)	962	27-68	602	350	962	0	311	210	441
Chronic including sacroiliac	461	32-75	311	150		All	361	70	30
Disk (preoperative diagnosis)	172	30-68	121	51	20	66	39	25	108
					86 unclassified				
Arthritides: osteo, rheumatoid, and mixed types. No response to previous treatment	1,479	19-82	861	618	102	910	584	545	350
					467 unclassified				

Fig. 1. — Ultrasonic unit used in diagnosis. Subject immersed in water (coupling); screen at top reveals image of soft tissue detail. Courtesy of Howry, D. H.[8,9]

use of ultrasonic waves in outlining tissue structures (figs. 1 and 2).

Ultrasonic Units and Technical Application

The qualified technician plays an emphatic role in the application of physical energies, and ultrasound is no exception. The supervising physician is usually well occupied with proper diagnosis and allocation of therapy. Too often he is not totally familiar with technical details and depends upon the technician for ultimate execution of the prescription. Technicians are the field scouts who live with the patients, and in the ultrasonic range they have contributed immeasurably to origin, modification, and establishment of application, now responsible for correcting previous ambiguities. Their aid to this report has been basic, and their future observations will likewise be imperative.

Generating units are important. While they may differ in some engineering respects, there are now basic accepted standards that are established and uniform. First, frequencies of near 1,000 kilocycles are universally accepted as the choice for treatment of deeper structures. Units aimed at treating the skin and more superficial structures may also contain a circuit of higher frequency. Secondly, the soundhead (transducer) is the true "heart" of the energy production. Some controversy exists relative to its detail, but we believe that the larger crystal and soundhead combine has the advantage of a more equal distribution between central and peripheral beam energy, and a lessening of the "bundling effect" in relation to the total circumference of exposure. For the past eight months, one of us (K. P.) has been using a specially constructed soundhead still larger in diameter (3 inches) which contains more than one crystal. We are most favorably impressed with its comparative results and believe it to be another advancement in engineering. Regulations are now established by the Federal Communications Commission to maintain uniformity. Continuous energy is used in some units, while pulsating with a "work-rest" ratio cycle is utilized in others. We prefer the latter, and cannot avoid the inference that the former, at high dosage, has been responsible for misnomers reaching the literature using the term "ultrasonic diathermy." "Diathermy," a term significant during the early developmental period of physical agents, has become so misused that scientists may become confused. The word has no modern place in connection with either short wave or ultrasound. The very root derivation of the term proves that it has not, and to continue using it in connection with these modern energies distorts the visual concept of the clinician. Ultrasound is definitely not diathermy by any conceivable analysis.

Dosage represents the next imperative phase of technical application. It commands a spectrum so broad, we venture an opinion that most of the

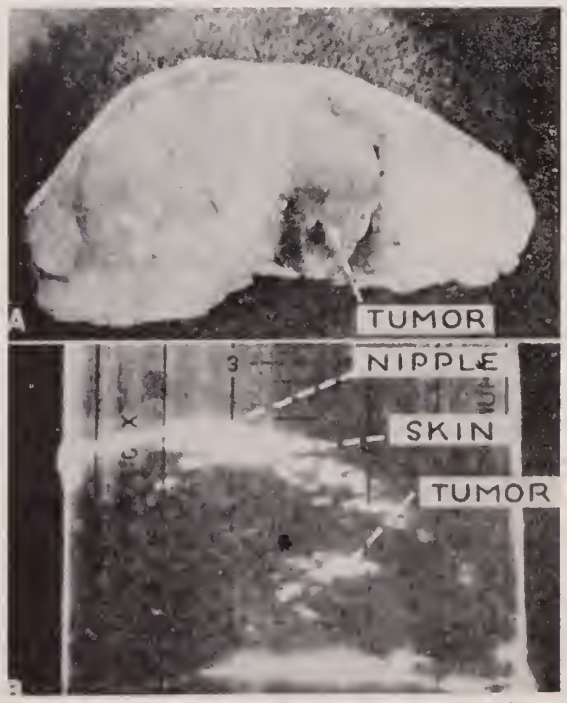

Fig. 2. — Section from breast containing malignant tumor. A. Gross appearance. B. Tumor outline revealed by exposure to ultrasonic waves prior to sectioning. Courtesy of Howry, D. H.[8,9]

Fig. 3. — To illustrate proper position of soundhead during treatment. Strips are used to guide operator in the proper coverage of the area to be treated.

current clinical frustration is due to a lack of proper concept in dosage application. Dosage engulfs intensity (watts), time (single exposure, frequency of treatments and total exposures) and method of application (stationary or rotary movement). It even involves the energy itself (whether continuous or pulsed), and we believe that much controversy relative to contraindications can be clarified by a proper concept of dosage. As would be anticipated with any therapeutic agent, when the basic scientific anlage stems from worldwide investigations, certain terminology must be unified. Wattage, therefore, has been confusing since its specificity is interdependent upon the unit used and the technic of application. Some units indicate to the operator watts per square centimeter; others, total watts of output, but calibrated so that the watts per square centimeter can be easily calculated.

Since universal agreement is approaching that the therapeutic dosage will usually range between 0.1 and 1.0 watts per square centimeter, we reiterate the plea of Phillips and his associates[12] for unification of dosage technic. Figure 3 demonstrates one example of using a "strip" technic for simplification. The article of these authors should be studied for other details.

A suggestion of our technical staff is convincingly practical, namely, to divide dosage terminology into three clinical intensities — low, medium, and high, the low representing 0.1 - 0.4, medium 0.3 - 0.5, and high 0.5 - 0.8 watts per square centimeter. The convenience, simplicity and practicability of such a system to the clinician is obvious. In our tables we use this system of dosage.

Time enters into dosage, but its significance is less than that of intensity. It is more pliable and dependent upon the particular machine unit used. Our average time per treatment is eight to 15 minutes, dependent upon the surface area to be covered; the frequency is from daily, in the acute case, to twice weekly as progress is made, and a total course varies, according to the relief obtained, from one to 15 treatments. We believe that ultrasonic energy will not falsify. If results are to be obtained, they will be obvious in six treatments. If not, then extension of the course will be problematic. Obviously, these variables in technical application will change with experience and progress.

Clinical Results

In order to remain within the space limit, tables are presented to summarize, but still convey three objectives: (1) the total number of cases representing various conditions treated by us with clinical results; (2) the evaluation of ultrasound compared to conventional physical modalities for the same disease; and (3) the portrayal of the adverse reaction ratio of ultrasonic energy in comparison to that of other therapeutic agents, both physical and chemical. A study of tables 1, 2 and 3 will further detail these aspects. In table 2, it should be noted that percentages listed in the last column represent the ratio of opinions expressed by the entire supervisory, clinical and technical staff combined, and not the percentage of total cases.

Contraindications and Dangers

As with all therapeutic agents, physical or chemical, clinical sense and judgment must be exercised in the use of ultrasound. When this approach is made and overenthusiasm to high dosage is restrained, the contraindications to ultrasound are few. We do not sound directly over the eye, heart, or pregnant uterus. Earlier, workers cautioned relative to the stellate ganglion area; but we have sounded this area thousands of times with no deleterious effects.

The bugbear that has crept into the minds of general physicians has been, first, destruction of tissue, and secondly, possible generalized reaction.

Table 2. — Tabulation (All Authors) Portraying Evaluation and Their Opinion of Ultrasound Compared to Other Modalities

Clinical Condition	Total Cases	Dosage Ultrasound Low, Medium, High 0.3 0.5 0.8 W/cm₂	Previous Physical Therapy	Comparison of Ultrasound with Other Therapies Equal	Superior	Inferior
Bursitis, acute	1,806	Low, medium	Chemotherapy, microwave, diathermy, heat.	0	100%	0
Bursitis, chronic	1,003	Medium, high	These measures plus needling	25%	75%	0
Arthritis group	1,479	Low, medium, high	Other physical agents. Serums, chemotherapy, plus physical agents	90%	80%	25%
Acute traumatic sprains	2,877	Low, medium	Routine	0	100%	0
Low back syndrome (including disks)	1,595	Low, medium, high	Physical agents, braces, traction and chemotherapy	25%	75%	0
Post fracture pain (ribs and limbs)	366	Low	Many routine measures	0	100%	0
Dupuytren's contracture (Dr. Carter)	6	Low, medium	Various routine measures, nonsurgical		100%	

Both are humbugs, provided clinical "horse sense" is exercised, and table 3 proves that they are. If simple aspirin were chosen for comparison, the reaction ratio would overshadow ultrasound so far that the latter would appear to cause no adverse reaction.

There is a definite reason for this "fear complex." It is relevant that we expose it because the "fear phantom" will not stand up under scientific scrutiny, and yet it has demoralized the clinical altruistic mind.

For concentrated analysis we cite a current article, research in content, appearing in a clinical journal 30 days prior to this writing. Lehmann, Baldes and Krusen [13] reported exposing onion root tips to ultrasonic energy at 110 watts per square centimeter (clinical dosage 0.1 - 1.0 watts per square centimeter), used a frequency of one megacycle, for five minutes, under a pressure of 450 pounds per square inch. Subsequent microscopic analysis revealed destruction of the root tips. This report typifies others, including some by the same authors, which have misled and confused practical physicians.

There is nothing wrong with the report of these authors; Lehmann is a brilliant scientist. Clinical physicians, however, seeking therapeutic applications, fail to differentiate the significance and become horrified. In their turmoil of practice, they have little time to analyze scientifically and distinguish between clinical and experimental reports when both are appearing in clinical periodicals. The concise differential here is simple when scientifically analyzed. With Lehmann's experimental set-up compared to therapeutic application, one could not expect to iron a shirt with a steam roller and still not burst the buttons. Likewise, a door can be normally closed without noise or distortion of the surrounding structures; but it can conceivably be slammed with such force as to crumble the plaster. Both are comparable to ultrasound because primarily it begins as a mechanical force.

Phillips[10] cited the details of a European survey covering 101,629 cases treated with ultasound. One Australian clinic reported a few reactions two to three days after treatment, and restlessness, giddiness or nausea was experienced by

Table 3. — Combined Tabulation (All Authors) Showing Infrequency of Reaction with Ultrasound

Dates	Total Cases Treated (All Authors)	Total Treatments Given	U. S. Dosage Most Frequently Used Low	Medium	High	Adverse Reaction Local	General
1951 to 1956	Mass total cases—all conditions 15,368	92,208	X	X		Tissue damage or reaction — none Aggravation of local symptoms—16	Vertigo, nausea or nervousness—42. All showed unstable autonomic balance

30 patients with a pre-existing labile autonomic nervous balance. The others reported no reactions. Table 3 records the ratio of this study, which is infinitesimal when compared to the reaction ratio of other therapeutic remedies.

Within the past few weeks we have been increasingly interrogated by clinicians from various areas relative to chronic injury to the hands of operators using ultrasound over long periods of time. It is evident that these clinicians are disturbed, and a current comment is imperative. We contacted and have received replies from the research laboratories of three leading manufacturers of ultrasound equipment (Birtcher Corporation, Burdick Corporation, and R. J. Lindquist Company). Their information coincides with our experience, and in summary follows.

During the early European work there was experienced some neuritis and distress in the hands of operators, obviously from a transducer (soundhead) which emitted ultrasound energy backward, or when operators, while sounding under water, submerged their hands. The manufacturers assured us that the design of their transducers has long since corrected this "back lash," and they have not received complaints from the therapeutic field.

In the departments of one of us (K.P.), there are operators who have used ultrasound for four years, have given several thousand treatments, and have experienced no unfavorable reaction to their hands other than that of fatigue neuralgia. Recent roentgenograms of their hands show no abnormal changes. Caution is reiterated against operators erroneously submerging their hands during treatment.

Conclusion

Ultrasound energy is a new and valuable physical agent.

Its clinical effectiveness is more pronounced in acute conditions than in the chronic ailments of similar type.

Technical application together with proper soundhead construction is important.

Safety, when this agent is properly applied, is more assured than it is with the conventional physical agents previously used.

Ultrasonic energy is superior in clinical effect to other physical agents in selected clinical conditions.

Recognition and credit are properly accorded the following technicians who, over the past four years, diligently pursued and established uniform technics, and accumulated and tabulated case data, thereby contributing much to the objective of the report: Amina W. Barber, R.N.; Marie Saunders, R.N.; Bernice Blanchard, P.T.; Elma Froid, P.T.; Vince W. Matteson, P.T.; Oram M. Rochester, P.T.

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1150 S. W. Twenty-Second Street, Miami 45 (Dr. Phillips).

Medical District Meetings Program

The programs for the four Medical District Meetings are published in this issue of The Journal on page 364.

The meetings are being held October 30 at Tallahassee, October 31 at Ocala, November 1 at Tampa and November 2 at West Palm Beach.

All members will receive printed programs prior to the meetings.

Fractures of the Neck of the Femur and Intertrochanteric Fractures

James J. Callahan, M.D.
CHICAGO

Fracture of the hip is a common generalized term applied to all fractures about the upper portion of the femur. The patient and his family are often confused by the term, and wonder exactly where the fracture is. They should be helped to understand the pathologic status.

Statistics

According to our private hospital figures, fractures involving the intertrochanteric area seem to carry a higher mortality than fractures involving the neck of the femur; however, based on a five year review of Cook County Hospital figures, the incidence is the same for the two types of fracture (table 1). In a private hospital with a series of 66 patients with intertrochanteric fractures over a five-year period, 30 were operated on, with a mortality of 6 per cent. In the nonoperative group, the mortality was 36 per cent; four of these patients died within the first 48 hours; their general physical condition was such that surgery could not have been performed. By definition, *nonoperative* means either that the general condition precluded operation or that the fracture was too comminuted for surgery, so much so that even the use of a Blade plate could not have reduced the mortality.

Regarding the neck of the femur, out of a total of 73 private patients, 58 were operated on; of these patients, four died, leaving a percentage of 6.7. Those not operated on showed a 6.5 per cent mortality. The immediate cause of death was arteriosclerotic heart disease.

Etiology

The cause of the fracture is usually entirely different in the two locations: *Intertrochanteric* fractures result from *direct* trauma; that is, the patient falls directly on the upper portion of the femur in the greater trochanteric area. This direct fall accounts for the serious comminution of the greater trochanteric area or intertrochanteric area. Usually the fall occurs while the patient is doing some type of manual labor: climbing a ladder, putting in a window, or washing the windows or screens. Because of the trauma, complications are greater, especially vascular phenomena and deposition of fat emboli.

Fractures involving the *neck of the femur* usually result from *indirect* trauma. The patient may slip or trip, and in the sudden attempt to catch himself from falling, a violent contraction of the muscles takes place with severe spasm of the external rotators. This results in avulsion of the neck of the femur with the distal fragment being externally rotated or everted. In other words, in a fracture of the neck of the femur, the patient slips, fractures the neck of the femur and then falls—in that sequence. In the intertrochanteric fracture, the opposite occurs; the patient falls, and in doing so, fractures the femur.

Classification According to Surgical Risk

In order to determine the advisability of surgery or the degree of surgical risk, ratings of 1, 2, 3 or 4 are ascribed. A rating of 1 means that there is no objection; the patient is in excellent condition for surgery; all the requirements are fulfilled. A rating of 2 indicates that the general condition is good, but some supportive treatment is needed. A rating of 3 represents questionable operative risk unless response to supportive treatment encourages the hope of operative survival. A rating of 4 contraindicates surgery without qualification, because of generally poor physical condition; treatment must be conservative.

Common Errors in Treatment

Common errors in treatment[1] are in the main the following:

1. Too vigorous manipulation without first securing muscle relaxation by traction.
2. Inadequate immobilization of the fracture with resultant deformity and disability, such as external rotation. In fractures

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Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami Beach, May 14, 1956.

Table 1.—Comparative Statistics on Femoral Neck and Intertrochanteric Fractures In Charity and Private Hospitals

Cook County Hospital

1. Femoral Neck, 1950, 51, 52, 53, 55

Year	Total	Operation	Deaths	Mortality	No Operation	Deaths	Mortality
1950	156	97	16	16%	59	19	32%
1951	135	76	8	10%	59	24	40%
1952	151	84	14	16%	67	30	45%
1953	150	38	8	21%	112	33	30%
1955	139	29	7	23%	110	35	32%
Total	731	324	53	16%	407	141	34%

2. Intertrochanteric, 1950, 51, 52, 53, 55

1950	178	36	10	28%	142	55	39%
1951	203	36	2	6%	167	62	37%
1952	232	16	2	12%	216	56	26%
1953	232	16	2	12%	216	56	26%
1955	219	19	5	26%	200	72	36%
Total	1053	142	23	16%	911	306	34%

Private Hospital

Femoral Neck	73	58	4	6.7%	15	6.5%
Intertrochanteric	66	30		6.6%	36	36.3%

of the neck of the femur, wires and small pins should not be used; a flange or two screws are preferable.

3. Failure to maintain proper weight-bearing line.
4. Failure to take advanced age of the patient into consideration, especially in intertrochanteric fractures in which associated arthritis calls for length compensation at the conclusion of treatment to prevent ultimate shortening. Without such compensation there will be shortening in more than 90 per cent of the cases within a year or a year and a half.
5. Age is also an important consideration because the general condition of an already debilitated patient may be worsened by trauma and the complications of this type of fracture. The amount of surgery necessary for the insertion of a plate may overtax the patient who might live without surgery. Conservative treatment will save lives that may be lost by ill-advised surgery.
6. Failure to apply traction properly.
7. Failure to hold the fragments in correct position by a sling apparatus.
8. Failure to observe and to record the status of the pulses and the neurologic condition of the extremities at the time of initial treatment.
9. In comminuted intertrochanteric fractures, the only internal fixation permissible is Blade fixation.
10. Too small a ring when the Thomas splint is used results in pressure necrosis.

Treatment

What is the best form of treatment after a patient has sustained either an intertrochanteric fracture or a fracture of the neck of the femur? Basically, the intertrochanteric fracture needs rigid immobilization. There is virtual unanimity that the correct form of treatment calls for the use of a plate or of screws; that is, some type of internal fixation. Fracture of the neck of the femur, in my opinion, does *not* call for rigid immobilization or fixation. This is contrary to the opinion of most other surgeons. I personally believe that fractures of the neck of the femur should not be rigidly immobilized, but should be placed in the correct position and secured in that position with some form of internal fixation but *not rigidly secured.* Again, contrary to the practice of most surgeons, I employ traction immediately as a preliminary treatment for all fractures involving the upper portion of the femur. The delay for traction before surgical intervention grants time for necessary evaluation of the patient's condition and provides time for his recovery from shock and from concomitant complications. Most surgeons believe that surgery

should be performed immediately or at least within the first 48 hours after the accident. Even if the patient's condition can be evaluated within the first 48 hours, I am still not of that opinion, because, if, as is well known, showers of fat emboli are found in the heart, liver, and brain following the fracture of a small bone, how much more fat may be expected as a result of a traumatic fracture in a cancellous bone such as the neck of the femur and the bones of the intertrochanteric areas?

Fractures of the Neck of the Femur.—Fractures of the neck of the femur may be treated by one of three methods: (1) conservatively, traction and if the patient's condition does not improve, then continue with this conservative treatment; (2) by the closed reduction method by means of pinning through a small incision over the greater trochanter; (3) by open reduction of the fractured neck of the femur. The preliminary treatment is the same as for all fractures of the femur: Traction is exerted for one week or 10 days in order to give the patient an opportunity to overcome the shock caused by the injury. During this period, reinforcement therapy, including the administration of plasma and whole blood transfusions, is prescribed. All related pathologic disorders should be treated and, if possible, eliminated before an anesthetic is administered. Only then should the decision as to the type of treatment be made.

Rationale of Open Reduction.—The third type of treatment, by open reduction, is my preference, because the fracture can be seen and can be reduced accurately and because the surgeon can be sure that there is no soft tissue interposition. Such observation is not possible with either of the first two methods—the conservative treatment or by closed reduction by pinning through a small incision over the greater trochanter. The advisability of open operation may be disputed. Open operation, however, in my experience, alone offers the advantage of permitting the circulation to be evaluated, which is important in this type of fracture. Furthermore, there is the opportunity to observe whether reduction is correct and immobilization adequate. If the edges of the fragments are serrated, they can be fitted together; the surfaces may be freshened, thus eliminating questions of rotation of the head with resultant vascular complications. There is, moreover, the opportunity to remove any of the capsule that may be in between the fractured parts. Reasonable prognosis depends on open operation. If the posterior capsule has been ruptured and is ecchymotic, and the proximal fragment does not bleed freely, bone will not be grown. In such cases an early reconstruction operation is preferable to waiting a period of months only to find that the head is not viable.

Aseptic Necrosis.—Regardless of the method employed, aseptic necrosis will occur in a certain percentage of cases. Even though the fractured neck of the femur heals, aseptic necrosis of the head may occur at any time from 18 months to three to five years after injury. When this complicating condition ensues, an arthroplasty with the use of a vitallium cup or fascia lata is recommended. When the articulating surface of the acetabulum is smooth, a reconstruction may be performed by remolding the head of the femur without the use of any foreign material. Successful hip joint function may be obtained by this method.

Either the Colonna or Whitman reconstruction may be used when the head becomes necrotic. The necrotic portion is removed from the head, the greater trochanter is removed, and the area from which it was removed is rounded and placed in the acetabulum. It is well to remove the lesser trochanter at the same time that the greater trochanter is removed, so as to prevent further complications. The patient is then immobilized in plaster with abduction of the limb and slight internal rotation. Usually the immobilization period is from four to six weeks.

Classification of Fractures of the Neck of the Femur.—Fractures of the neck of the femur may be subdivided into Base, Central or Midportion, and Subcapital.

Fractures of Base of Neck of Femur.—Prognosis for an excellent anatomic functional result will be favorable if there are a broad base, cancellous bone, and a good blood supply, provided such fractures are properly reduced without soft tissue or capsular interposition, and provided they are maintained in that position by some form of internal fixation.

Base and Central Fractures.—Central fractures or fractures of the midportion of the neck of the femur are the commonest of all neck of the femur fractures. Both the base and central fractures should be operated on after the preliminary period for traction with 20 to 25

pound's weight. There is time for evaluation during the traction period. Blind pinning should not be done. An open operation with exposure of the fracture site to make sure that there is no soft tissue between the fragments is an essential step in treatment.

When we began hip pinning years ago, patients were prepared exactly as if they were going to have a closed pinning. In a series of 250 cases, we found that one of six cases showed a soft tissue interposition at the time of the arthrotomy. We also found that many of the patients who appeared to have a good reduction at the time of surgery did not, in fact, have complete reduction.

Again, it is imperative that the fragments be pulled into valgus position, and that the injured member be at least a half inch longer than the uninjured leg so as to insure a good ultimate result of equal measurement of the two legs.

SUBCAPITAL FRACTURES.—Subcapital fractures are the most serious of all fractures of the neck of the femur. This type of fracture nullifies all statistics. It is the one fracture that does not unite and in which aseptic necrosis occurs more frequently than in any other type of fracture of the neck of the femur. Subcapital fractures should be divided into two groups: those occurring in patients under 60 or 70 years of age, and those in patients over 70. In the ones under 70, treatment is the same as for central or midcervical fractures. Patients are placed in traction; an open operation is performed, and the fragments are pinned. If the circulation is at all doubtful, however, an early reconstruction operation is far better than pinning; otherwise, some type of reconstruction procedure will be required at a later date.

For those patients over 70, immediate reconstruction is advisable, although it may seem radical until one realizes that all that such patients want is a good weight-bearing, painless limb. To avoid the unnecessary worry on the patient's part regarding questionable union, a long waiting period, and whether or not the particular pin will hold the fragments, the following steps are recommended: (1) Remove the head; mold the proximal portion of the distal fragment, and displace the greater trochanter; (2) take off the lesser trochanter if the neck is short, so as to eliminate articulation of the lesser trochanter with the inferior margin of the acetabulum; (3) align correctly for weight bearing, so that there will be neither internal nor external rotation.

In young patients in the subcapital group, surgery should be performed just the same as for base and central fractures. This is the group that lowers the statistics, so far as union of bone is concerned, because generally subcapital fractures are notorious for nonunion; however, in the young, I believe that this type of operation should be performed.

For the aged patient with a subcapital fracture of the neck of the femur, following one week in traction and sufficient support to the patient's fluid balance, remove the head of the femur and perform a reconstruction operation by removing the greater and lesser trochanters. Place the proximal portion of the distal fragment in the acetabulum and apply a body cast for approximately four weeks. By this procedure, aged patients are ambulatory in a shorter time, and there is no question of whether or not there will be a union of the bone. Although this appears to be a radical procedure, gratifying results have been obtained.

Patients over 70 years of age with subcapital fractures of the neck of the femur are ideal candidates for arthroplasty of the hip with removal of the lesser trochanter.[3] The procedures of Dr. Royal Whitman and Dr. Paul Colonna are essentially the same as mine with this modification by me: removal of the lesser trochanter and enough of the posterior portion of the upper femur to permit better fitting of the newly formed head in the acetabulum. The step-by-step technic has been outlined elsewhere.[2] The posterior bulge must be removed in order to have the proximal portion of the distal fragment of the femur fit correctly into the acetabulum so as to permit a reconstruction operation. This procedure should be done immediately. Here again, I know that many would prefer the use of a replacement prosthesis and I am of another opinion.

The disadvantages[3] of such prosthetic devices are now well recognized: (1) absorption at the site of the metal and bone; (2) decalcification of the proximal portion of the distal femur, which sometimes happens; (3) loosening and even breaking of the prosthesis as a result of flaws; (4) soft tissue contraction; (5) excessive scar tissue formation and even bone formation following extensive incisions of the ilium; (6) individual susceptibility to metal and to resins.

What better material can one use than the patient's own bone in this repair? The shorten-

ing in a fresh case will be less than half an inch; early motion is assured; there is nothing to break, nothing to take out, and no waiting period for healing of a fracture. This is the one procedure that permits patients to be ambulatory in a short time. Immobilization in a cast for two weeks following surgery is usual. When the sutures have been removed, another cast is applied, and the patient is encouraged to walk while in this second cast. The total period of immobilization following surgery is from four to six weeks, followed by active motion.

It is true that many do have a resulting slight Trendelenburg's appearance, but they also have a stable weight-bearing member which is not painful.

Intertrochanteric Fractures. — Intertrochanteric fractures are classified into two groups: A and B. Group A comprises the group with severely comminuted fractures in which conservative treatment without surgery is advisable. Group B comprises those with fractures in the intertrochanteric area which are not severely comminuted.

Group A.—The various forms of plates are almost impossible to insert when comminution is severe. Plates will not hold; open reductions are excessively long, difficult, and shock-producing; infections, nonunions, and even death may ensue. No form of internal fixation should be used. The treatment of choice for this comminuted type is immobilization for approximately eight weeks. Some cases will require longer periods, but usually eight to ten weeks is sufficient. The patient should be placed in continuous traction or in a unilateral body spica. This form of conservative treatment has been gratifying in our hands; nonunion has been rare.

One rule must be adhered to, however, and this is true in intertrochanteric fractures whether treated conservatively or operatively. The fracture must be pulled down into a valgus position; that is, overpulled to increase the angle so as to produce a fourth inch to a half inch lengthening of the injured member at the end of treatment. This is done in order to maintain the normal length of the leg. If, after either the conservative or operative method, the leg is not three-fourths inch to one inch longer than before the accident, the patient will not have a good anatomic end result. In a series of more than 100 selected cases, on follow-up returns over a period of two to 10 years, more than 90 per cent of the patients reported shortening on leaving the hospital. This occurred regardless of conservative or operative treatment when during treatment of the intertrochanteric fracture, the legs were of equal length. All those who had an elongation from a third to three-fourths or even one inch returned with normal leg length. Moreover, inasmuch as most patients with intertrochanteric fractures are in the upper age bracket in which arthritic changes have limited the amount of motion in the lumbosacral and sacroiliac joints, the compensation for shortening that takes place in normal adults does not take place for them; thus, these aged patients then have a residual limp. They report pain in the back rather than pain in the hip, which is caused by mechanical instability. That is why calipers should be worn after both conservative and operative treatment, to relieve weight bearing until the roentgenograms reveal union of bone.

Although I am committed to conservative treatment in intertrochanteric fractures, there are occasions when on opening the hip with the aim of inserting two screws, the greater trochanter is found to be comminuted more than appeared in the roentgenogram. It is then necessary to use either the Blount-Moore pin or multiple screws or pins for fixation in order to secure this complicated fracture.

It is reasonable to treat younger patients with severely comminuted fractures with a Blount-Moore pin likewise.

The preliminary immediate treatment[1] consists of skin traction of approximately 25 to 30 pound's weight in balanced direct suspension traction. If the intertrochanteric fracture is broken into two pieces, including the avulsion of the lesser trochanter, operation should be performed through a lateral incision to expose the fractured site. Immobilize the fracture with two screws, or with a plate of the Blount-Moore or Newfield type. The two screw method has been successful.

After operation, the patient is placed in 5 pounds of traction until the skin has healed. After a weight-bearing caliper has been applied, the patient becomes ambulatory. The advantage of this form of treatment is that the patient can be up and about within a period of three weeks.

Group B. For Group B, comprising those with fractures in the intertrochanteric area which are not severely comminuted, operation is advised after the preliminary waiting or evaluation period of about a week. The surgery is not extensive. Two screws will usually be sufficient

to hold this type of fracture. The two wood screws are inserted through a small incision into the greater trochanteric area and into the neck of the femur. I realize that this is against all the rules and regulations of orthopedic surgery; nevertheless, my results are demonstrably as good as or superior to those obtained by any other extensive method of repair. If this simple method fails, then the more extensive plate method will also fail, because evidently there will have been an error in judgment in operating in the first place. This, I know, will evoke comment and perhaps refutation; but this procedure has proved wise through the years in my hands. The treatment advocated lessens the period of immobilization and permits early ambulation—within two or three weeks.

After traction or traction and surgery, an ischial non-weight-bearing caliper must be fitted in all intertrochanteric fracture cases as a precaution, because it requires at least four to six months for complete union of bone. A caliper admittedly may cause external rotation; nevertheless, this does not outweigh the benefits to be had from this brace in postponing weight-bearing.

Summary

Intertrochanteric fractures carry a high mortality, perhaps higher, according to some private hospital statistics, than fractures of the neck of the femur.

Intertrochanteric fractures should be treated either by traction, if severely comminuted, or by the two-screw method of immobilization, if not severely comminuted, followed by the use of an ischial non-weight-bearing caliper.

Fractures of the neck of the femur require open operation. The base of the neck and the central portion should receive internal fixation by means of a flange; subcapital fractures in the young require a flange; in the elderly, a reconstruction operation immediately at the time of surgery; a nonweight-bearing caliper is then employed until union of bone has taken place.

In intertrochanteric fractures the length of the leg should be from one-half to three-fourths inch longer following either the conservative or operative form of treatment; in fractures of the neck of the femur, the leg should be at least one-half to three-fourths inch longer than the opposite one. The main objective in placing the fractured neck of the femur in elongation is to bring the distal portion of the femur in a direct line under the head so as to favor approximation of the fractured surfaces by muscle pull.

Rigid fixation in the neck of the femur is not desirable; a control by a flange is sufficient to hold the fracture in the correct position of valgus deformity, with the distal portion directly under the head; the muscles can then perform their necessary function. The flange has a tendency to slip out after healing has begun. The disadvantage of rigid immobilization is that it does not permit the muscles to function in their normal manner, thus holding the fractured surfaces apart rather than permitting the muscles to approximate in the normal manner.

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Combined Tetracycline-Vitamin Therapy in Infections of the Urinary Tract

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Pollack and Halpern[1] emphasized the importance of maintaining adequate nutrition during disease and especially directed attention to the possibility of rapid vitamin depletion during stress situations. Low grade infections of the urinary tract as a group are likely to persist longer and recur more frequently than some other bacterial infections; for this reason they are especially likely to deplete the defensive and nutritional reserves of the body, and may be particularly amenable to nutritional therapy.

In stress situations due to infections that respond to antibiotic therapy, it is rational to accompany chemotherapy with a nutritional regimen designed to maintain or restore essential metabolites. Not only should dietary protein be increased, but vitamins also should be administered in quantities adequate to maintain normal body reserves.

Several of the broad spectrum antibiotics are now available in combination with the vitamin formula recommended in stress situations by the National Research Council. Dumas, Carlozzi and Wright[2] showed that the presence of this vitamin stress formula does not alter the blood level of tetracycline obtainable with tetracycline alone; Marti-Ibãnez[3] in a recent editorial critically discussed the use of antibiotic-vitamin combinations in treating the "whole" patient; and such combinations have been used clinically with good success in surgical infections,[4] pediatric infections,[5] and other infections.[6]

Because penicillin is ineffective against the gram-negative organisms encountered in many infections of the urinary tract, reliance has come to be placed principally on the broad spectrum antibiotics in the treatment of these disorders.[7-9]

Tetracycline, the newest of the broad spectrum antibiotics, has received preliminary clinical tests in infections of the urinary tract which suggest that it is better tolerated than some other broad spectrum drugs, and that its therapeutic value is comparable to that of the best of them.[10]

The study reported here was undertaken to determine the effectiveness of tetracycline fortified with the therapeutic vitamin formula recommended by the National Research Council as reported by Pollack and Halpern.[1]

Materials and Methods

A study was made of combined tetracycline-vitamin therapy in 36 unselected cases of various infections of the urinary tract. All were characterized by significant pyuria or by culture of pathogens from specimens of urine.

The standard daily dose was 1 Gm. of tetracycline together with 10 mg. of thiamine, 10 mg. of riboflavin, 100 mg. of niacinamide, 20 mg. of calcium pantothenate, 2 mg. of pyridoxine, 1.5 mg. of folic acid, 4 micrograms of vitamin B_{12}, 300 mg. of ascorbic acid, and 2 mg. of vitamin K. This is the "stress formula" of vitamins recommended by the National Research Council. Three of the patients, children under six years of age, were given half this daily dose. In all cases the daily dose was divided into four equal portions given at six hour intervals.

In most cases the tetracycline-vitamin therapy was continued for five days. In four cases infection following urinary stasis required therapy for periods up to 18 days; in three of these there was eventual response to treatment.

In 26 of the cases, weekly bacteriologic cultures were made of specimens of urine collected aseptically; in one case of prostatitis the prostatic fluid was cultured instead.

In these cases the effectiveness of the antibiotic-vitamin therapy was evaluated in the following way: a patient was judged bacteriologically cured only when, after antibiotic therapy was stopped, no growth occurred in urine cultured 48 hours; clinically improved when symptoms sub-

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Tetracyn-SF (brand of tetracycline in combination with therapeutic "stress formula" vitamins) was kindly supplied for this study by Dr. M. William Amster, Medical Department, Pfizer Laboratories, Brooklyn, N.Y.

sided, but bacterial culture continued to show the presence of pathogens; and unimproved when therapy was discontinued with no significant effect.

In 10 cases pathogens could not be demonstrated on culture, or urine was not cultured. These are treated separately in the discussion; the results of therapy were judged clinically and by the gross and microscopic appearance of the urine.

Results

Table 1 indicates the results of tetracycline-vitamin therapy in the 26 cases in which progress was evaluated by urine cultures. It is clear that nonsurgical infections responded more consistently to therapy than did postoperative infections. In the former, improvement was noted in 93 per cent of cases, while in the latter, there was benefit in only half of the cases. It is likely that the high incidence of resistant organisms in the postoperative infections was due to the prevalence of high resistance in bacteria normally in the hospital.

Table 1. — Bacteriologically Evaluated Cases

Diagnosis	Bacteriologic Cure	Clinical Improvement	No Improvement
Nonsurgical urinary tract infection	8	5	1
Prostatitis	3	3	—
Postoperative infection	—	3	3
Total	11	11	4
Per cent	42.3	42.3	15.4

The most frequently occurring organisms in cultures in all 26 cases were coliform bacilli, which occurred in about one third of the cases. Proteus vulgaris and Streptococcus faecalis were present in over a quarter of the cases, and Alcaligenes faecalis, Staphylococcus aureus, nonhemolytic streptococci, and Pseudomonas aeruginosa each occurred in more than one case. Tetracycline-resistant strains were encountered most frequently in the Proteus infections; cultures in seven out of 10 cases were resistant by the paper disk test. Resistant forms of other organisms appeared less frequently in the cultures. The four cases that were completely refractory to therapy yielded in culture only resistant P. vulgaris and coliform bacilli. It is interesting that in one case, in which only Pseudomonas resistant to tetracycline could be cultured, bacteriologic cure of the infection was effected by ordinary therapy with tetracycline.

The 10 cases in which bacteriologic culture failed to yield pathogens or was not made are summarized in table 2. The results were evaluated by microscopic examination of urine and by the clinical response of each patient. All 10 of the patients were benefited by the tetracycline-vitamin combination, and in six of these the response was judged excellent.

Table 2. — Clinically Evaluated Cases

Diagnosis	Excellent Response	Fair Response	No Response
Pyelonephritis with hematuria	2	—	—
Prostatitis with hematuria	1	3	—
Pyuria	2	1	—
Epididymitis	1	—	—
Total	6	4	—

Summary

Substantial clinical improvement was obtained in 89 per cent of 36 cases of various common infections of the urinary tract when the patients were treated with tetracycline fortified with the therapeutic vitamin formula recommended by the National Research Council. Many of these infections were caused by organisms that are often refractory to antibiotic therapy, and it is believed that the combined antibiotic-vitamin therapy was responsible for the rapid eradication of these infections, and for the generally uneventful convalescence of the patients, as well as for the high proportion of successful cases.

While the number of cases is insufficient in itself to permit a critical evaluation of this therapy, these results together with those observed in other clinical trials of antibiotic-vitamin combinations justify their extended use. In this series of cases, one patient suffered mild nausea which was easily controlled; no other side effects of the drug were observed. In view of the remarkable effectiveness and safety of the tetracycline-vitamin preparation used in this study, it should find a high place in the treatment of infections that are likely to be protracted and accompanied by nutritional deficiencies.

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Weather Aspects of Tallahassee Polio-like Outbreak

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In 1954 a serious outbreak of what has been referred to as the Tallahassee strain of polio or polioencephalitis (hereafter referred to as P-E) occurred in Tallahassee. The records of the Leon County Health Unit show that from May to mid-December, 451 cases had been reported by local doctors. This figure represents about 1 per cent of the population of Leon County. Most of the cases (388) occurred in September and October with October 1 being the peak day.

The concept of a "polio season" and the rather commonly held idea that a cold snap will break the back of a polio epidemic prompted me, a meteorologist and not a physician, to study the meteorological conditions that existed during the Tallahassee outbreak to see if any correlations could be found between weather and this particular strain of polio.

The P-E Curve

Figure 1 shows a curve of the reported cases of P-E with time. The data were smoothed slightly as follows: Consider three consecutive days a, b, and c, having six, eight, and five cases, respectively. Instead of plotting eight for day b, a value $X = \frac{a + 3b + c}{5} = 7$ was plotted. This was done for each day, and figure 1 is the resulting curve. The reason for this smoothing will be discussed.

The data used were supplied by the Leon County Health Unit, and the cases were recorded as occurring on the date when the first symptoms appeared, as near as the physician could determine. Many light cases occurred which were not reported, but the per cent of the cases occurring which was reported probably remained about constant throughout the epidemic, so that the sample used is probably a representative one.

The curve in figure 1 shows three main maxima and several smaller maxima. September 14 was the first day to show as many as three cases, and the daily reports drop again to three cases or less after October 30. The study is limited to this one and one-half month period so as to prevent the possibility of working with a sample which is too small to be representative. An average of eight cases per day was reported during this period, and 83 cent of all of the 1954 cases occurred in this relatively short time. The highest daily total of 32 cases occurred on October 1 with September 26 and October 25 having 23 and 26 cases, respectively.

The Meteorological Parameter

All of the meteorological variables commonly observed at the earth's surface were examined.[1] Daily values of maximum and minimum temperature, maximum and minimum pressure, average wind direction and speed, average relative humidity, average sky cover and precipitation were plotted with the use of the same time scale as in figure 1. No correlations were apparent between the P-E curve and the curves of precipitation, wind speed and wind direction. The curves of relative humidity, maximum temperature, minimum temperature, minimum pressure and sky cover, however, appeared to be similar to the curve in figure 1.

Meteorological happenings seemed to be followed in about 10 days by significant changes in the P-E curve. It was found that the daily temperature range, which is simply the difference between the daily maximum and daily minimum temperatures, was more consistently related to the P-E curve than was the minimum temperature itself. That is, during the early part of the outbreak when the minimum temperature fluctuated little from day to day, the daily fluctuations in the maximum temperature took on an added significance.

In summer, in Tallahassee, one is most uncomfortable when the minimum temperature is high, the daily range of temperature small, and the midday relative humidity high. The discomfort is increased when low pressure is added to this set of conditions. If one assumes that physical resistance is also at a minimum under such conditions, then it is reasonable to combine tem-

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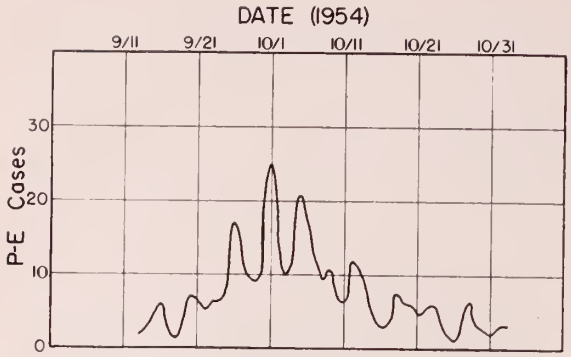

Fig. 1. — Curve of P-E epidemic (slightly smoothed).

perature range, relative humidity and pressure to obtain a curve where the maxima indicate discomfort and perhaps low physical resistance.

Figure 2 shows such a curve. The meteorological variables have been combined in such a way as to give them what was believed to be the proper weight and the proper algebraic sign. The temperature figure was obtained by subtracting the daily range from 22 degrees F., which was about the average range during the period. The pressure figure was obtained in a similar manner by subtracting the minimum daily pressure from the mean minimum pressure for the period, which was about 1,015 millibars. The average relative humidity at 1:30 p.m. for the period was about 55 per cent. Fifty-five per cent was subtracted from the daily 1:30 p.m. values and the results divided by four so as to weight properly this variable. The three variables then were added algebraically to make up the curve in figure 2, hereafter referred to as the meteorological parameter. These variables had the following limits: Temperature range, from + 14 to –15; pressure, from +10 to –9; relative humidity, from +9½ to –9. It can be seen that the temperature variable was weighted a little more heavily than the other two variables, the ratio of the three being about 3:2:2. The meteorological parameter shown in figure 2 has been smoothed in the same manner as the P-E curve in figure 1.

Comparison of the P-E Curve with the Meteorological Parameter

The numbers below the curve of the meteorological parameter indicate the number of days after each maximum and minimum that a corresponding maximum or minimum appeared in the P-E curve. The lag varies from 13 to seven days with an average of about 10 days. A fairly regular change in this lag is noted with time. It varies from 12 or 13 days early in the period to about eight days near the end of the period.

For purposes of comparison, the curve of the meteorological parameter was adjusted so that all of the maxima and minima occurred exactly 10 days prior to the corresponding maxima and minima in the P-E curve. This adjustment has the effect of squeezing both ends of the curve toward the middle. For example, a maximum or minimum in figure 2 which occurred 13 days before a corresponding maximum or minimum in the P-E curve was moved three days to the right, and one with an eight day time difference was moved two days to the left, and so on. Then the adjusted curve was shifted 10 days to the right and superimposed on the P-E curve. Figure 3 shows this superposition, the dashed curve being the adjusted meteorological parameter. The correspondence of the two curves is striking. Fairly large differences in the amplitudes of the two curves are noted at the end of the period although the phase relation is still valid. They are primarily due to the fact that the near steady state type of summer weather is giving way to the variability of fall weather, and therefore the variables making up the meteorological parameter are not properly combined to give comparable amplitudes. The first two cold fronts of the fall season passed Tallahassee at the points marked CF on the dashed curve, the second one setting record low temperatures for the time of year. A secondary reason for lack of amplitude correlation near the end of the period may be the fact that the P-E outbreak was on the wane. A low of two cases was reached on October 17, nine days after the first cold front passed, and a low of zero cases on October 26, eight days after the second cold front passed.

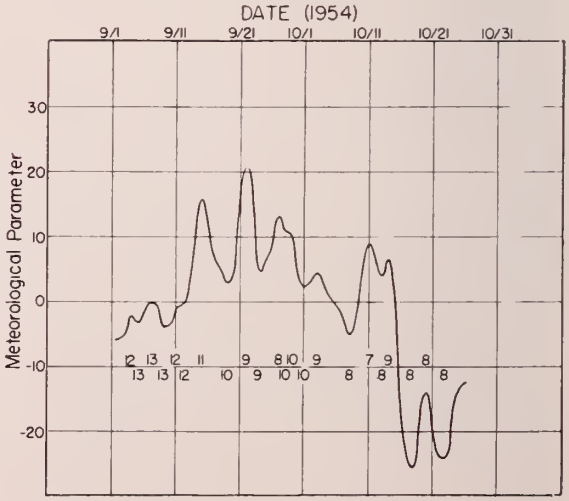

Fig. 2. — Curve of meteorological parameter (slightly smoothed).

Curves of the daily values (unsmoothed) of P-E incidence and the meteorological parameter are not presented, but they showed a high degree of correlation. This is implied, of course, by the fact that the smoothing technic which was finally adopted smoothes to only a slight degree. A three day running mean type of smoothing proved to be too gross, tending to eliminate significantly correlated features.

The Incubation Period

The average lag of 10 days between the maxima and minima in the meteorological parameter and the P-E curve seemed to be compatible with what was considered to be the average incubation period in this particular epidemic. In a large number of cases it was thought that the period fell between one and two weeks.

Epidemiological evidence suggests that incubation periods may vary during epidemics, having a tendency to become shorter as the epidemics progress. This would tend to support the variation from about 13 to eight days shown by the numbers below the curve in figure 2.

In order to determine the magnitude of the incubation period and its possible variation with time, a check was made of a number of cases in which at least one date of exposure was known. The results are shown in figure 4 (solid curve). If there was more than one known exposure for a given case, the date of the first known exposure was used. The number of cases used in obtaining the weekly averages are also shown in figure 4. It is believed that only the four week period from September 15 to October 12 contains enough cases to be reliable. Not only does the latter part of

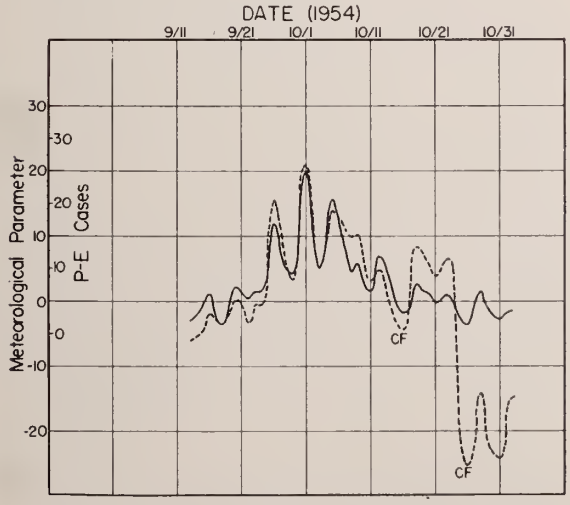

Fig. 3. — P-E curve (solid line) with adjusted curve of meteorological parameter superimposed (dashed line).

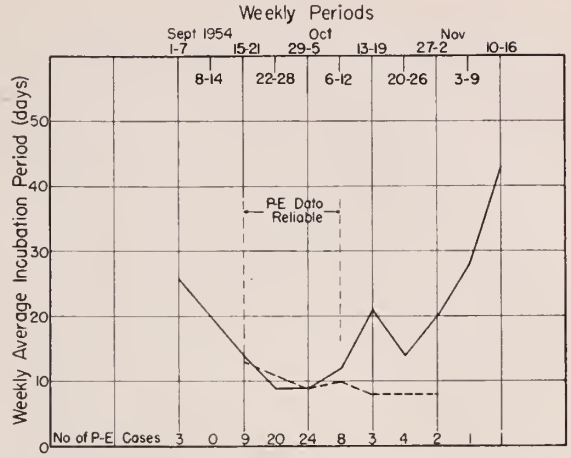

Fig. 4. — Comparison of time lag between maxima and minima in curves in figures 1 and 2 (dashed line) with incubation period determined from a sample of P-E data (solid curve).

the solid curve (after October 12) have too few cases to be reliable, but also a point has been reached in the epidemic where those coming down with the disease have probably been exposed several times. To pick the proper exposure from several, even if the dates of all of the exposures were known, would be impossible. The fact that the first known exposure was picked, when more than one was known to exist, may be reflected in the tendency for the solid curve to go up again in late October and early November.

The dashed curve in figure 4 represents the weekly average incubation period as determined from the lag between the maxima and minima of the meteorological parameter and the P-E curve. This dashed curve agrees well with the solid curve in the region where the latter is considered to be reliable, the mean difference being only one day. After October 12, it may be that the dashed curve fairly well represents the trend in the average incubation period because it is not subject to the limitations of the solid curve. For example, if a person is being exposed every day or nearly every day, it seems plausible that he will pick the day when his physical resistance is lowest to contract the disease, if he is going to contract it at all. It is also evident that the curves superimposed in figure 3 show good correlation between small maxima and minima as well as the larger ones. The limitation of a small sample, therefore, does not enter the dashed curve in figure 4 as strongly or directly as it does the solid curve.

Armstrong's Research

Dr. Charles Armstrong of the National Institutes of Health compared epidemics of poliomyeli-

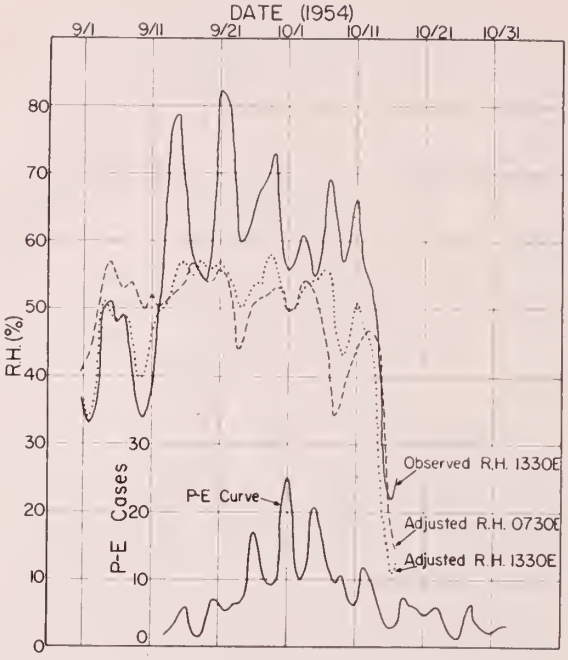

Fig. 5. — Comparison of various relative humidity (R.H.) curves with P-E curve.

tis with relative humidity.[2-4] His theory was that the nose and throat region is a portal of entry for the polio virus. The dryness or moistness of this region apparently hinders or enhances the ability of the virus to infect the individual. Armstrong presented evidence of laboratory tests on mice which tends to support his theory. He reasoned that inhaled air of high relative humidity has a lesser drying effect on the mucous membranes than air of low relative humidity. It is known that the exhaled air has a temperature of about 90 F. and a relative humidity of 90 per cent. He therefore adjusted the actual relative humidity, measured at 7 a.m., to what it would be if the temperature were 90 F. The result was a measure of absolute humidity, and its variance from 90 per cent represented the drying effect on the mucous membranes.

Having established that high relative humidity is conducive to high incidence of polio, Armstrong presented curves of polio epidemics and adjusted relative humidity. Some of his curves were monthly averages and some showed weekly averages. The weekly averaged curves showed a high degree of correlation with about a three week lag, which he attributed to the incubation period of polio.

Application of the Armstrong Technic

It is worth noting that the present correlation had been completed before I became aware of Armstrong's work. An application of Armstrong's technic to the Tallahassee polio-like disease revealed the following:

1. That neither the 0730E nor 1330E relative humidity adjusted to a 90 F. temperature correlates well with the P-E curve (fig. 5).

2. That the actual relative humidity at 1330E correlates better with the P-E curve than do either of the adjusted relative humidities (fig. 5).

3. That the meteorological parameter shows a far better correlation with the P-E curve than any of the three relative humidity curves.

The curves in figure 5 are three day weighted means just as in figures 1, 2 and 3. To compare better with Armstrong's results, figure 6 shows weekly averages of the same variables presented in figure 5. Again it is seen that the meteorological parameter shows the best correlation with the P-E curve.

General Remarks

It is noteworthy that here as well as in Armstrong's work, a high degree of correlation was noted between atmospheric variables and disease. The atmospheric variables differ as do the diseases in all probability; the Tallahassee disease virus is still unidentified. Armstrong's theory is no doubt more scientifically sound than mine, but the fact that Armstrong's technic does not give a good correlation in this case indicates that some important differences exist.

In addition to the fact that the diseases are no doubt different, the amount of smoothing of data may be important. Armstrong might not have achieved a good correlation using daily values or three day weighted mean values. As shown in figure 6, however, weekly averages of

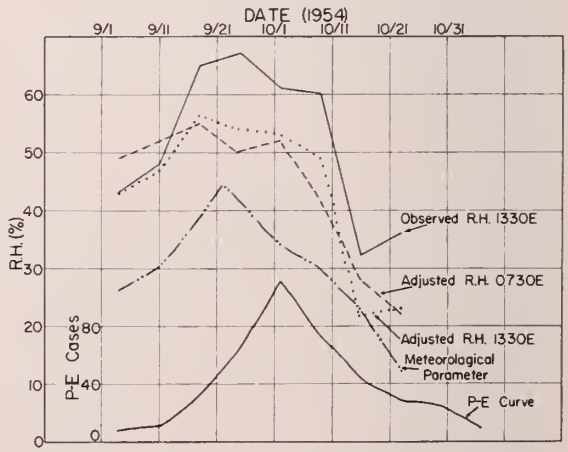

Fig. 6. — Comparison of weekly averages of various relative humidity (R.H.) curves and meteorological parameter with weekly totals of P-E cases.

the adjusted 0730E relative humidity do not correlate well with the Tallahassee epidemiological curve; so it may be that the smoothing is unimportant and that the entire difference lies in the nature of this unidentified disease.

In the present case, no correlations were evident between the precipitation curve and the P-E curve. The fact, however, that in 1954 Tallahassee experienced its driest year since precipitation records have been kept (over 50 years) may well have played an important role in the origin and intensity of the outbreak.

The curve of average sky cover, mentioned earlier, was almost an exact duplicate of the 1:30 p.m. relative humidity curve; so it was not included in the meteorological parameter.

No claim is made that meteorological conditions in any way caused the P-E outbreak. There does appear to be a strong possibility, however, that the maxima and minima in the curve of the meteorological parameter had a governing effect on the maxima and minima in the P-E curve. The general shape (frequency and amplitude) of the P-E curve could have been accurately predicted at least one week in advance simply by changing the time scale of the meteorological parameter by 10 days.

Summary

Curves of a polio-like outbreak and a combination of meteorological variables are presented and compared. There appears to be a high degree of correlation between the two curves when an adjustment is made for a time lag which averages about 10 days. The average time lag appears to be in good agreement with the average incubation period as determined from a study of a sample of the total cases. A technic used successfully to correlate poliomyelitis with absolute humidity did not give a good correlation when applied to the Tallahassee disease.

Thanks are due to Dr. Joseph M. Bistowish Jr., Leon County Health Officer, and Dr. Bernard F. Rosenblum, U. S. Public Health Service physician presently assoicated with the Leon County Health Unit, for supplying the data for figure 1 and part of figure 4, and for advice on the medical aspects of the study. Dr. Robert H. Mickler of Tallahassee and Dr. M. D. Hicklin of the U. S. Public Health Service also served as medical consultants. Appreciation is expressed to Mr. Jesse W. Smith of the Tallahassee Weather Bureau Station for providing the necessary meteorological data.

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Florida State University.

ABSTRACTS

Educational Needs — Anesthesiologist's Response. By Ralph S. Sappenfield, M.D. J. A. M. A. 159:1435-1436 (Dec. 10) 1955.

In his chairman's address, presented before the Section on Anesthesiology at the 104th Annual Meeting of the American Medical Association in June 1955, Dr. Sappenfield mentions the versatility of the present day anesthesiologist, which is utilized in many ways other than administering anesthetics. He observes that today, through his knowledge of the basic sciences, this specialist is also a clinical physiologist and pharmacologist. Now that increasing recognition of the importance and quality of the intellectual challenge has led many to enter this field, they are building a structure of improved care with greater safety to the patients.

In his discussion of advancement of education and research facilities, this author notes that a quality of anesthesia care equal to the quality of surgical care is lacking in too many localities, creating a problem which hospital associations are requesting assistance in solving, especially with regard to adequate anesthesia coverage for the smaller institutions. He also discusses the role of the part time anesthesiologist, the general practitioner, who administers a large percentage of anesthesia throughout the United States. In addition, he outlines the current anesthesiology programs designed to meet the need for better patient care as voiced by the hospital administrators and the earnest desire for more knowledge by the general practitioner.

In conclusion, Dr. Sappenfield notes that anesthesiology has been made deceptively easy and, therefore, potentially dangerous in the hands of the inexperienced. In his opinion, the general practitioner in regular hospital work can and must do better than perpetuate outmoded methods of the past.

Eight Patients with Adrenal Cortical Hypofunction Surviving More Than Fifteen Years. By Leonard G. Rowntree, M.D., J. A. M. A. 159:1527-1529 (Dec. 17) 1955.

The survival time in cases of adrenal cortical hypofunction (Addison's disease) has generally been materially prolonged through modern methods of treatment. The purpose of this article is to report the unusually prolonged survival time in several of the author's cases. Eight patients have survived for over 15 years. This covers an experience in the treatment of more than 150 patients seen during the last 35 years. In a series of eight consecutive patients (1933-1940) treated with Swingle's suprarenal cortical extract and with an adequate intake of salt daily, all survived for at least nine years, seven survived 10 years or more, and five survived from 15 to 18 years. Two patients recovered. In several patients recourse was made to other adrenal preparations; two received pellet implantations late in the course of their disease, and two were given small doses of cortisone. Eight cases, all previously reported in detail, are reviewed.

The survival time in this series sets a new record in adrenal cortical hypofunction though the number of cases concerned is admittedly small. The results here presented suggest the desirability of finding ways and means to make Swingle's suprarenal cortical extract more generally available and at a lower cost or to compound some balanced mixture of adrenal hormones that will serve as an effective and inexpensive substitute.

Cyclodiathermy: Results in Various Types of Glaucoma. By Sherman B. Forbes, M.D. Am. J. Ophth. 40:650-666 (Nov.) 1955.

This comprehensive study evaluates the role of cyclodiathermy in the treatment of various types of glaucoma. It includes an analysis of a series of 80 cases treated over a five year period. In more than half of these cases, treated in the later years of this period, the new technic of placing the diathermic applications a greater distance from the limbus (6.0 to 10 mm.), and in refractory cases approaching the long ciliary vessels and nerves along the recti muscles, was employed with improved results. The old technic is reviewed and the new technic is described. Eight illustrative cases are presented.

This presentation is offered to suggest that: (1) cyclodiathermy is a safe and frequently an effectual procedure fraught with no more complications than the older procedures; (2) it may be performed as a preliminary procedure or simultaneously with a cataract extraction in indicated cases; (3) it does not mutilate or distort the ordinary pathways of an extraction, thus posing no difficulties should cataract surgery later become necessary; (4) it may be repeated with safety at proper intervals twice or even three times in different areas; and (5) it requires the minimal period of hospitalization.

The author concludes that cyclodiathermy has a role of great potential value in congenital glaucoma, open angle glaucoma, narrow angle (iris block) glaucoma to a lesser degree, glaucoma associated with congenital defects of the globe, and secondary glaucoma of all types. Also, it has special value in combination with certain operative procedures. The paper is presented in the hope of stimulating the development of an operation which would offer a solution to the problem of glaucoma surgery; the ideal approach would be to affect favorably the rate of aqueous production and also the facility of aqueous outflow.

Complete Perineotomy. By C. B. Cunningham, M.D., F.A.C.S., and J. W. Pilkington, M.D., F.A.C.S. Am. J. Obst. & Gynec. 70:1225-1229 (Dec.) 1955.

The authors define complete perineotomy as the deliberate extension through the sphincter ani or into the rectum of a median episiotomy (perineotomy) when the presenting part of the fetus jeopardizes the integrity of the external sphincter muscle or the rectal wall. They review the advantages and limitations of median and mediolateral episiotomies and stress the superiority of the median technic, despite its single disadvantage of extension into the rectum.

In their series of 290 pelvic deliveries in private primiparous patients, 31 of the patients were subjected to complete perineotomy. It is their conclusion that the perineotomy can be employed exclusively in pelvic deliveries and complete perineotomy when necessary, with excellent results and without alteration of routine postpartum care.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

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The Great Clinician

The smoke and the acrid odor of the last French "seventy five" is gone. Those who remember stand by in an era to mark a grave — some with sadness, all with affection. The great clinician is gone.

It is not that he wore a frock coat or leather puttees that endears him to our affection. His empty knowledge of modern methods and specialized procedures did not do it. His source of information was of his times, not ours. We do not admire his Victorian formality.

Quite naturally you scan the horizon of your memory to think of him for a moment. Maybe you recall him as an individual, or perhaps you see him hazily but can recite a favorite line of his. Something he said or thought may have stuck with you as a guide or counsel through the years. Surely you recognize such a man.

His life and his actions were affected by the customs and beliefs of his day. He was hampered by the empiricism and the handed down dictums he inherited from the past. The advance of scientific knowledge and the great development of specialized fields in medicine made it almost impossible for one man to master the field. Where is the great clinician today?

Research, investigation, and multi-discipline study furnish the means for learning new facts and for extending the borders of our attack on disease. It offers a life of interest, security, and excitement.

Teaching is a rewarding experience and has been a sacred trust of the physician since before Aesculapius and the tablets on Mount Olympus. The life of the teacher can be full and his rewards great. He lives on in the lives of those who love him and call him preceptor. Here is a privilege in medicine.

The physicians in government work, in public health, in military service, and in industry all serve a human need. All of these fields offer opportunity for the life and service of the physician's choice. Each covers one facet of the work to be done. Each is important.

The man with long and special training, who practices in a limited field of medicine, contributes much to the profession, has an opportunity to follow his bent in study, and can live a life of service and respect. His rewards are great.

The family physician — the general practitioner, be he in the city, close to the farm, or in

a fishing village — comes close to people. He has the chance to know life, to feel the warmth of human relations, and to be a part of the community in which he lives and strives.

Into which of these branches of the profession did the great clinician go? The roll call by titles will not find him. Research worker, teacher, physician, surgeon — these names will not describe him.

He was of his times and he knew the lacks of his day. Somewhere along the way, he found the wisdom of understanding and the confidence that comes from trying yet knowing failure. His capacity to love was boundless. He knew beauty and was simple. He was tireless in his work and his study.

A search for answers, a contagious inquiry of mind, an impatience with the lack of knowledge in his day, were characteristics which affected his students. These drives and attitudes, when combined at the bedside or laboratory table with the humility, gentleness and strength of his mien, were part of this man.

The divisions of labor within our profession — the schools, the laboratories, the work to be done, the patients to be seen; all these things must be divided out. The responsibilities must be set to get the job done, but there is a deeper need.

This deeper need is to furnish a fertile soil for men in the other branches of medicine to obtain the advantages of training and experience offered by the limited field. In this way, Florida will see the great clinician. In this way only, can the opportunities of the state be used to nurture the characteristics which make a man great.

Here lies, not the grave of an era, rather a cornerstone of new cooperative effort and interdependence among the opportunities within the state.

The smoke of the "seventy five" is gone. The frock coat and cane have given place to the clothes of today, but the Great Clinician has not changed.

Attention All Members
District Meeting Time

The democratic processes by which the Florida Medical Association operates are well exemplified in the annual District Meetings, which begin their seventeenth round late this month. The original purpose of these meetings was twofold: (1) to bring to the individual members a stimulating scientific program involving a minimum expenditure of time and travel on their part, and (2) to give them a convenient opportunity to know personally the officers they had chosen to run their Association and to discuss with these officials administrative, socioeconomic and other problems.

This approach has the same objectives today. It takes the Association to the members at the grass roots level, as it were, in truly democratic fashion so that the officers and members may share excellent scientific programs and be free to counsel together in friendly informality. The officers' midyear progress report on the Association's program imparts up-to-the-minute information to the members, prompts inquiries from them, and provides an ideal time for them to air their views. Thus the officers gauge the sentiment of the membership, and the members evaluate the leadership and progress of the Association.

The District Meetings have taken an added importance in recent years as their role has broadened in the efforts to improve the status of the medical profession in these changing times. They offer an ideal channel through which to promote more participation, more general activity, and more cohesion among all the members of the Association. They provide a forum for thorough discussion, for the necessary "give and take" to resolve internal misunderstanding and disagreement, and for constructive suggestions regarding the many phases of activity within the Association. The interchange of ideas in these meetings is an invaluable means to that unity of effort which alone will solve many of the problems that beset the profession today.

Liaison between the Association and the county medical societies can be greatly strengthened through the District Meetings. They bridge the gap well at midyear and strengthen the whole program. Here the delegates to the annual meeting may receive preparation for their responsibilities that will enable them to act much more intelligently in the House of Delegates.

These meetings provide a proving ground for better public relations. Here the key points of this vital aspect of medical progress are set forth. Better care of patients is the only sound basis for good public relations, and the district gatherings

serve in dual capacity to present scientific stimulus and to integrate local and state planning on the socioeconomic level.

The District Meetings are a great asset to the Association, but to a large extent only potentially so. They are an asset that is being squandered because so few members appreciate their intrinsic worth sufficiently to attend. Regrettably, the vast majority of the members are not availing themselves of a large return on a very small investment. Is it too much to ask the members of the Association to invest one afternoon and evening a year in enjoying fellowship at these meetings with colleagues of their immediate area and the officers of their state society?

A goodly number of members are already planning to attend this year and have marked the date on their calendar. If each one of these members would recruit now a fellow-member to attend with him, the attendance would be doubled. There is yet time to promote interest and make the District Meeting in each of the four districts a greater asset than ever before.

The program for this year's series of meetings, scheduled for Tallahassee, October 30; Ocala, October 31; Tampa, November 1; and West Palm Beach, November 2, is in this issue of The Journal. The President, President-Elect and Secretary-Treasurer of the Association, the Editor of The Journal, the deans of the state's two medical schools, and the essayists on the scientific program will be present to welcome the members in each district. This is the year for the members to welcome them by attending in record numbers.

Medical District Meetings October 30-31 — November 1-2

Discussions of regional ileitis and colitis will be the features of the four Medical District Meetings scheduled for October 30, 31 and November 1, 2 at Tallahassee, Ocala, Tampa and West Palm Beach respectively. The programs for the seventeenth annual meetings have been announced by Dr. Herschel G. Cole, of Tampa, chairman of Council. Each program was arranged with the assistance of the councilors of the particular medical district.

The district councilors are also in charge of local arrangements. For the meeting in the Northwest District at Tallahassee, they were made by Drs. Alpheus T. Kennedy, of Pensacola, and Walter J. Baker, of Foley. In the Northeast District for the meeting at Ocala, Drs. Leo M. Wachtel Jr., of Jacksonville, and Charles L. Park Sr., of Sanford, are in charge. For the meeting at Tampa in the Southwest District, Drs. C. Frank Chunn, of Tampa, and Gordon H. McSwain, of Arcadia, made the arrangements, and in the Southeast District, Drs. Ralph M. Overtstreet Jr., of West Palm Beach, and Ralph S. Sappenfield, of Miami, arranged for the meeting at West Palm Beach.

A group of eight physicians, two from each medical district, has been selected to discuss regional ileitis and colitis at each of the four meetings. Dr. Cole explained, however, that the program has been planned in order that the general practitioner and the specialist would be equally rewarded.

Dr. Herschel G. Cole, Tampa
Chairman of Council

Honored guests at each meeting will be Dr. George T. Harrell Jr., dean of the College of Medicine, University of Florida, and Dr. Homer F. Marsh, dean of the School of Medicine, University of Miami.

Following each scientific program, officers of the Association are to present brief talks. Scheduled to speak are Drs. Francis H. Langley, of St. Petersburg, President; William C. Roberts, of Panama City, President-Elect; Samuel M. Day, of Jacksonville, Secretary-Treasurer, and Shaler Richardson, of Jacksonville, Editor of The Journal of the Florida Medical Association.

Each meeting is scheduled to begin at 2:00 p.m. At 6:00 refreshments are to be served followed by dinner at 7:00, with the exception of the meeting at Ocala where dinner is to be served at 8:00.

All members of the Association will receive printed programs prior to the meetings.

The annual Workshops of the Woman's Auxiliary are to be held in connection with each Medical District Meeting. Mrs. Scottie J. Wilson, of Fort Lauderdale, president of the Auxiliary, has announced that the four vice presidents have made plans for the meetings and will preside. Mrs. Bernard M. Barrett, of Pensacola, will preside at Tallahassee; Mrs. Lee Rogers Jr., of Rockledge, at Ocala; Mrs. Augustine S. Weekly, of Lutz, at Tampa, and Mrs. Willard L. Fitzgerald, of Miami, at West Palm Beach.

Scientific Assemblies - Four Medical Districts

Tallahassee—A

Tuesday, Oct. 30—2:00 p.m.

W. T. Edwards Tuberculosis Hospital

Presiding: Herschel G. Cole, Chairman of the Council, and Walter J. Baker, of Foley, Councilor of District 2.

Address of Welcome, Robert H. Mickler, President, Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society.

"Problems in the Diagnosis and Medical Treatment of Regional Ileitis and Colitis," Fred A. Butler, Tallahassee.

"Problems in the Diagnosis and Surgical Treatment of Regional Ileitis and Colitis," Earl E. Wilkison, Tallahassee.

Discussion

Ocala—B

Wednesday, Oct. 31—2:00 p.m.

Silver Springs Restaurant

Presiding: Herschel G. Cole, Chairman of the Council, and Charles L. Park Sr., of Sanford, Councilor of District 4.

Address of Welcome, William J. McGovern, President, Marion County Medical Society.

"Problems in the Diagnosis and Medical Treatment of Regional Ileitis and Colitis," Fred Mathers, Orlando.

"Problems in the Diagnosis and Surgical Treatment of Regional Ileitis and Colitis," C. Burling Roesch, Jacksonville.

Discussion

Tampa—C

Thursday, Nov. 1—2:00 p.m.

Palm Room—Tampa Terrace Hotel

Presiding: Herschel G. Cole, Chairman of the Council, and C. Frank Chunn, of Tampa, Councilor of District 5.

Address of Welcome, James N. Patterson, President, Hillsborough County Medical Association.

"Problems in the Diagnosis and Medical Treatment of Regional Ileitis and Colitis," John R. Neefe, St. Petersburg.

"Problems in the Diagnosis and Surgical Treatment of Regional Ileitis and Colitis," Edmund P. Kelley, Sarasota.

Discussion

West Palm Beach—D

Friday, Nov. 2—2:00 p.m.

West Palm Beach Cabana Club

Presiding: Herschel G. Cole, Chairman of the Council, and Ralph S. Sappenfield, of Miami, Councilor of District 8.

Address of Welcome, Walter R. Newbern, President, Palm Beach County Medical Society.

"Problems in the Diagnosis and Medical Treatment of Regional Ileitis and Colitis," Donald F. Marion, Miami.

"Problems in the Diagnosis and Surgical Treatment of Regional Ileitis and Colitis," Charles McD. Harris, West Palm Beach.

Discussion

Southeastern States Cancer Seminar November 7-9, 1956

The Southeastern States Cancer Seminar will be held at the Hotel George Washington in Jacksonville on November 7-9. This Seminar is presented biennially. It is sponsored by the Cancer Committee of the Duval County Medical Society, the Florida Medical Association and the Division of Postgraduate Education of the College of Medicine of the University of Florida, and supported by the American Cancer Society, Florida Division, and the Florida State Board of Health.

This course is approved for credit, and there is no registration fee.

The list of lecturers constitutes a roster of a representative number of the most distinguished names in this field of medicine. The eminent speakers and the well chosen subjects should attract an unusually large attendance from throughout the Southeast. The program follows:

SOUTHEASTERN STATES CANCER SEMINAR
NOVEMBER 7-9, 1956
JACKSONVILLE

MORNING

November 7

8:00- 8:30 Registration
8:30- 8:35 Welcome address, President, Duval County Medical Society
8:35- 9:00 Early Recognition and Treatment of Breast Tumors
Dr. Everett D. Sugarbaker
9:00- 9:25 Treatment of Recurrent and Late Carcinoma of the Breast
Dr. Elliott E. Scarborough
9:25- 9:55 The Value of Extended Surgery for Carcinoma of the Breast Including:
(a) Internal Mammary Dissection
(b) Oophorectomy
(c) Adrenalectomy
(d) Hypophysectomy
Dr. Everett D. Sugarbaker
9:55-10:10 Intermission
10:10-10:55 Panel Discussion on Carcinoma of the Breast
(1) Dr. Everett D. Sugarbaker—Moderator
(2) Dr. William Meissner
(3) Dr. Eugene P. Pendergrass
(4) Dr. Elliott E. Scarborough
10:55-11:25 Radiological Aspects of Malignant Tumors of the Lung
Dr. Eugene P. Pendergrass
11:25-12:10 Surgical Aspects of Malignant Tumors of the Lung
Dr. Alton Ochsner

AFTERNOON

12:10- 1:30 Lunch
1:30- 3:00 The Role of Cytology in Early Diagnosis of Malignancies
(1) Dr. Emerson Day—Moderator
(2) Dr. Cyrus C. Erickson
(3) Dr. Ruth M. Graham
3:00- 3:15 Intermission
3:15- 3:45 Treatment of Carcinoma of the Cervix
Dr. Willard Allen
3:45- 4:45 Panel Discussion on Female Genital Neoplasm:
(1) Dr. Willard Allen—Moderator
(2) Dr. Emerson Day
(3) Dr. Cyrus C. Erickson
(4) Dr. Ruth M. Graham
(5) Dr. William Meissner
(6) Dr. Eugene P. Pendergrass
(7) Dr. Elliott E. Scarborough

MORNING

November 8

9:00- 9:30 Precancerous Lesions, Cutaneous Carcinogenic Effects of Sunlight, and Epitheliomas
Dr. George Clinton Andrews
9:30-10:00 Pigmented Nevi and Melanomas
Dr. George Clinton Andrews
10:00-10:15 Intermission
10:15-11:05 Tumors of Soft Tissues
Dr. George T. Pack
11:05-11:35 Hemangiomas
Dr. George Clinton Andrews
11:35-12:05 Panel Discussion on Tumors of the Skin and Subcutaneous Tissue
(1) Dr. George Clinton Andrews
(2) Dr. George T. Pack

AFTERNOON

12:05- 1:30 Lunch
1:30- 2:30 Tumor Chemotherapy
Dr. Alfred Gellhorn
2:30- 2:55 Tumors of the Lip and Oral Cavity
Dr. Elliott E. Scarborough
2:55- 3:20 Carcinoma of the Larynx
Dr. Edgar L. Frazell
3:20- 3:35 Intermission
3:35- 4:00 Surgery and Radioactive Iodine in Management of Tumors of the Thyroid
Dr. Edgar L. Frazell
4:00- 4:30 Panel Discussion on Tumors of the Head and Neck:
(1) Dr. Elliott E. Scarborough—Moderator
(2) Dr. Richard B. Cattell
(3) Dr. Edgar L. Frazell
(4) Dr. William Meissner
(5) Dr. Eugene P. Pendergrass

MORNING

November 9

8:30- 9:00 Carcinoma of the Stomach
Dr. George T. Pack
9:00- 9:35 Incidence, Detection, and Management of Polyps of the Colon
Dr. Michael R. Deddish
9:35-10:10 The Role of Radiology in Early Detection of Colonic Tumors
Dr. Robert D. Moreton

10:10-10:40 Recent Advances in Management of Cancer of the Colon
Dr. Richard B. Cattell
10:40-10:55 Intermission
10:55-11:25 Tumors of the Ampulla of Vater, and Carcinoma of the Pancreas
Dr. Richard B. Cattell
11:25-12:00 Panel Discussion on Diagnosis and Treatment of Carcinoma of the Colon and Stomach
(1) Dr. Michael R. Deddish—Moderator
(2) Dr. Richard B. Cattell
(3) Dr. William Meissner
(4) Dr. Robert D. Moreton
(5) Dr. George T. Pack

Florida Academy of General Practice Scientific Assembly Jacksonville, October 20-21, 1956

The Seventh Annual Scientific Assembly of the Florida Academy of General Practice will convene at the Hotel Roosevelt in Jacksonville on October 20 and continue through the following day. An excellent scientific program has been arranged which should attract a large attendance from within and without the state. In addition to all Florida members, all members of the American Academy of General Practice in Georgia, Alabama, Mississippi, Louisiana and South Carolina have received program announcements.

Dr. Alton Ochsner of New Orleans is one of the distinguished guest lecturers on the program on Saturday morning, October 20. Others include Dr. H. Keith Fischer of Philadelphia, Dr. A. Lee Lichtman of New York, Dr. E. Richard Harrell of Ann Arbor, Mich., and Dr. Howard M. DuBose of Lakeland, who represents the Florida Trudeau Society. The afternoon session will consist of a round table discussion on "Emotional Problems in General Practice," with all of the morning speakers participating.

A Symposium on Automobile Safety will be featured on Sunday morning, October 21, and in the afternoon a panel discussion will follow. The emphasis on the problem of injuries in accidents will be highlighted for the public on Saturday in a televised program from 5:00 to 5:30 p.m. over Station WJHP-TV. As a public service, the Academy has arranged to televise a panel presentation entitled "Medicine's Role in Injury and Accident Prevention." The speakers will be: Trooper D. R. Jansen of the Florida Highway Patrol; Dr. Preston Wade of New York City; Lt. Frederick L. McGuire, of the U. S. Naval Hospital, Philadelphia; Mr. Fletcher Platt, Director of Safety Research, Ford Motor Company, Dearborn, Mich., and Mr. John O. Moore, Director of Automobile Crash Injury Research at Cornell University Medical College, who will serve as moderator.

Radio and TV Station WMBR will provide a four minute news summary by one of its regular newscasters as a "between-the-acts" on the regular Assembly program.

On Saturday night the annual banquet will be held. Dr. Ochsner, who will be the speaker on that occasion, has chosen for the subject of his address the intriguing title, "The Influence of Serendipity on Medicine."

The Assembly is scheduled to follow immediately after the two day annual meeting of the Florida Clinical Diabetes Association, which also will be held in Jacksonville. Many physicians doubtless are planning to attend both meetings.

Dr. Leo M. Wachtel Jr., of Jacksonville, President of the Florida Academy of General Practice, is receiving the cooperation of the entire Jacksonville Academy in planning for and arranging the details of the Assembly.

PROGRAM

SEVENTH ANNUAL SCIENTIFIC ASSEMBLY
FLORIDA ACADEMY OF GENERAL PRACTICE
OCTOBER 20 - 21, 1956
HOTEL ROOSEVELT, JACKSONVILLE, FLORIDA
(Approved for 14 hours Category I credit)
SATURDAY, OCTOBER 20

9:00 Address of welcome, Dr. Leo M. Wachtel Jr., President, Florida Academy of General Practice
9:15 "Modern Drug Treatment of Tuberculosis," Dr. Howard M. DuBose, Lakeland, Florida, representing Florida Trudeau Society
9:50 "Emotional Problems of the Young Adult," Dr. H. Keith Fischer, Department of Psychiatry, Temple University, Philadelphia, Pa.
10:25 "Prevention and Treatment of Traumatic Injury in Athletes," Dr. A. Lee Lichtman, New York Polyclinic Medical School
11:00 Intermission

11:25 "Cutaneous Manifestations of Internal Disease," Dr. E. Richard Harrell, Department of Dermatology, University of Michigan
12:00 "Management of Ulcerations of Stomach and Duodenum," Dr. Alton Ochsner, Ochsner Clinic, New Orleans

Luncheon

1:30 Business Session
2:30 Questions and answers. Round table discussion on "Emotional Problems in General Practice," moderator, Dr. Fischer. All of morning speakers to take part.
8:30 Banquet. Dr. Ochsner, "The Influence of Serendipity on Medicine."

SUNDAY, OCTOBER 21
SYMPOSIUM ON AUTOMOBILE SAFETY

9:30 "Law Enforcement and Its Bearing on Accidents" film, "The Perfect Crime," Trooper D. R. Jansen, Florida Highway Patrol
10:10 "Total Treatment of Crash Injury Victim," Dr. Preston Wade, New York, N. Y.
10:50 Intermission
11:10 "Psychiatric Aspects of the 'Accident-prone' Driver," Lt. Frederick L. McGuire, Head of Psychology Department, U. S. Naval Hospital, Philadelphia, Pa.
11:50 "Safety Features of the Modern Automobile," Mr. Fletcher N. Platt, Ford Motor Company, Dearborn, Mich.

Luncheon

2:00 A Recapitulation by Mr. John O. Moore, Director, Automobile Crash Injury Research, Cornell University Medical College. Panel discussion, Mr. Moore, moderator

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World Medical Association and the American Physician

On Cuban Independence Day, October 10, The World Medical Association will hold the opening plenary session of its Tenth General Assembly in Havana, Cuba. This is the first time that an Assembly has been held in Latin America. The only other meeting held in the Western Hemisphere was the 1950 Assembly in New York City. The 1956 Assembly will continue through October 15.

Since this meeting takes place next door to Florida, the physicians of the state are fortunate to have this opportunity to attend and become better acquainted with this organization which has earned the right to call itself "the international voice of organized medicine." Now completing its ninth year, The World Medical Association is "a federation of the most representative national medical association in each of 52 nations." These member organizations represent more than 700,000 physicians, who, the world over, cherish the same basic ideals of conduct and the same devotion to the welfare of mankind.

In its efforts to cultivate the common purposes of the profession, this international body has become a strong factor in protecting and promoting the professional interests of the medical profession and the cause of world peace. It now has a well tried constitutional structure, a small but efficient secretariat, and a tri-lingual journal whose worldwide influence is rapidly growing. The permanent office of the secretariat is located in the United States.

The United States Committee of The World Medical Association has grown slowly but steadily, and last year attained a membership of 5,000 American physicians. A greatly enlarged membership program is now under way. America's world leadership challenges the physicians of this country to make the United States Committee a truly impressive and representative body of American physicians. As a first step in this direction, a questionnaire has been sent to all members of the committee asking them to indicate their county medical society affiliation and to signify how they personally would like to promote or participate in committee activities. Contemplated plans include more frequent liaison between the committee and its individual members, the development of local units of committee organization, and the holding of a formal meeting at the time of the 1957 annual meeting of the American Medical Association.

Dr. Marvin Olson, of Wisconsin, in recounting his experiences in attending General Assemblies of The World Medical Association, emphasized three areas in which he believes this organization is vital to the future of American medicine: (1) as

(Continued on page 370)

Graduate Medical Education
Florida Clinical Diabetes Association
Jacksonville, October 18-19, 1956

The Florida Clinical Diabetes Association will hold its fourth annual meeting at the Duval Medical Center in Jacksonville on October 18 and 19. The dinner meeting, which is an annual feature, is scheduled for Thursday evening, October 18, at 6:30 p.m., in the Hotel Roosevelt. On Friday evening at 8:00 p.m. in the auditorium of the Independent Life Building, there will be a meeting for the public, held in cooperation with the Diabetes Association of Duval County, with Mr. J. W. Stroud, its president, acting as moderator.

The scientific program of the Florida Clinical Diabetes Association will be presented in cooperation with the Florida Medical Association, the Florida State Board of Health, and the Division of Postgraduate Education of the College of Medicine of the University of Florida. Registration will begin at 8:30 a.m. on Thursday, and the fee of $10 carries with it the privilege of membership in the association. This meeting immediately precedes the annual scientific assembly of the Florida Academy of General Practice, to be held on October 20 and 21 at the Hotel Roosevelt in Jacksonville.

The guest speakers will be Dr. Samuel B. Beaser of Boston and Dr. Philip K. Bondy of New Haven, Conn. Dr. Beaser is Clinical Associate in Medicine at the Harvard Medical School, Head of the Diabetic Clinic of Beth Israel Hospital, and President of the New England Diabetes Association. Dr. Bondy is Associate Professor of Medicine at the Yale University School of Medicine, and Editor of the Section on Endocrinology and Metabolism in the Yearbook of Medicine and the Journal of Clinical Investigation. Member speakers on the program are Dr. Benjamin L. Brock of Orlando, Dr. George H. Garmany of Tallahassee, and Dr. Joseph H. St. John and Dr. Irvin C. Schneider of Jacksonville. Panel members are Dr. Samuel M. Wells and Dr. Thomas E. Hodgins Jr. of Jacksonville.

The program is as follows:

FOURTH ANNUAL MEETING
FLORIDA CLINICAL DIABETES ASSOCIATION
DUVAL MEDICAL CENTER, JACKSONVILLE, OCTOBER 18-19

THURSDAY, OCTOBER 18 Moderator: Dr. Richard H. Sinden, President

8:30	Registration	
9:30	The Mechanisms of Diabetes in the Light of Modern Knowledge	Dr. Bondy
10:15	Treatment of Diabetes Mellitus with the Arylsulfonylureas	Dr. Beaser
11:00	Recess	
11:15	Some Early Observations on Use of BZ-55 (Carbutamide) in Private Practice	Dr. St. John
11:35	Kidney Disease in the Diabetic	Dr. Bondy
	Moderator: Dr. George C. Austin	
2:00	Treatment of the Difficult Diabetic	Dr. Beaser
2:45	Recess	
3:00	Panel Discussion: Oral Diabetic Preparations Drs. Bondy, Beaser, Wells and Hodgins	
6:30	Dinner Meeting of the Association — Hotel Roosevelt	

FRIDAY, OCTOBER 19 Moderator: Dr. Edward R. Smith, Incoming President

9:30	The Medical Profession's Role in Diabetes Mellitus	Dr. Beaser
10:15	Treatment of Diabetic Acidosis	Dr. Bondy
10:45	Recess	
11:00	Diabetes Mellitus and Pulmonary Tuberculosis	Dr. Brock
11:20	Diabetes and Certain Complications	Dr. Beaser
	Moderator: Dr. Irvin C. Schneider	
2:00	Methods and the Diagnosis of Diabetes	Dr. Bondy
2:50	Problems of the Doctor and Patient in the Long Term Care of Diabetes	Dr. Garmany
3:15	Recess	
3:30	Clinic Presentation	Dr. Schneider
8:00	Public Meeting — Independent Life Building Moderator: Mr. J. W. Stroud Speakers: Drs. Bondy and Beaser	

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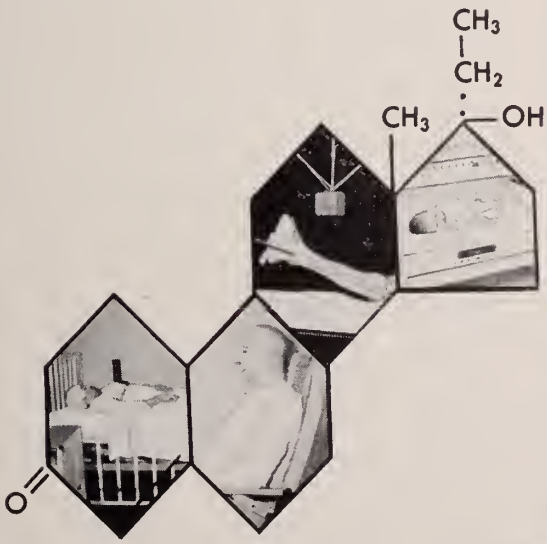

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(Continued from page 367)

the voice and guardian of professional freedom for the doctor; (2) as the promoter of higher standards of medical education and service in all member nations; and (3) as a practical contributor to the cause of world peace. "Through the World Medical Association," he said, "the universal language of medicine can be made more articulate in the cause of world peace."

Surely many physicians in Florida and throughout the nation will be eager to promote these objectives through this international voice of organized medicine. They can do so by joining the United States Committee. Every individual physician in the United States is eligible for membership. Dr. Austin Smith is president of the United States Committee, and Dr. Louis H. Bauer is secretary-treasurer as well as secretary-general of The World Medical Association, with headquarters at 10 Columbus Circle, New York 19, N. Y.

Southern Medical Association 1906 - 1956

This fall the interest of the members of the Southern Medical Association centers on its Golden Anniversary Celebration in early October in Chattanooga and its Golden Anniversary Meeting in Washington in mid-November. Many Florida physicians will participate in these meetings, and some will recall this state's role in the founding of this great medical society of the South.

At the Read House in Chattanooga on October 2 and 3 appropriate ceremonies will commemorate the founding of the association there half a century ago. Upon call of Dr. Giles C. Savage of Nashville, Tenn., then president of the Tennessee State Medical Association, representatives from Alabama, Florida, Georgia, Louisiana, Mississippi and Tennessee met at the Read House in that city on Oct. 2, 1906 to organize the Southern Medical Association. This body came into being with the adoption on October 3 of a constitution and by-laws drawn up by a committee composed of Dr. Jere L. Crook, chairman, of Jackson, Tenn.; Dr. Walter W. Crawford, of Hattiesburg, Miss., who was president of the Mississippi Medical Association that year; and Dr. H. H. Martin, of Savannah, Ga., serving at the time as president of the Medical Association of Georgia.

Unfortunately, the information about this first meeting is meager. As one of the six original

states, Florida was invited to send representatives, but their names remain obscure. The next year, Dr. John MacDiarmid, of DeLand, retiring president of the Florida Medical Association, was appointed to represent Florida on the Council. He served in that capacity from 1907 to 1910 and was succeeded by Dr. J. M. Jackson, of Miami, in 1911. Dr. Jackson was president of the association in 1912 and presided over the annual meeting held in Jacksonville that year.

Other presidents from Florida have been Dr. H. Marshall Taylor, of Jacksonville, in 1935, and Dr. Walter C. Jones, of Miami, in 1953. In addition to the Jacksonville meeting in 1912, four annual meetings have been held in Florida, all in Miami—in 1929, 1946, 1948 and 1952. Florida has been well represented in the Council across the years, and many of the state's leading specialists have been active in the numerous sections.

The historical and inspirational meeting in Chattanooga foreshadows a great annual scientific session in the nation's capital next month. From the beginning, the emphasis has remained on scientific medicine. The founding fathers provided in the constitution and by-laws they adopted at Chattanooga 50 years ago that "the exclusive purpose of this Association shall be to develop and foster scientific medicine. . . . It shall not at any time take active part in any economic, political or sectarian questions or concerted movements for securing legislative enactments." It was also provided at the outset that a physician must be a member of his county and state medical societies to be eligible to membership. These provisions have continued in effect to the present time.

Devoted exclusively to scientific medicine through the years, the association years ago expanded its membership beyond the borders of the six original states by making eligible to membership physicians who were members of the state and county medical societies in Arkansas, District of Columbia, Kentucky, Maryland, Missouri, North Carolina, Oklahoma, South Carolina, Texas, Virginia and West Virginia. From throughout the South, a large representation from its 10,000 members will gather in Washington on November 12 to 15 to participate in this fiftieth anniversary celebration. Many Florida doctors will be among those who will count it a privilege to participate in this great meeting. They are proud to be a part of this organization which since the beginning of the century has been a great force in advancing scientific medicine in the South.

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Bumbalo, T. S., Gustina, F. J., and Oleksiak, R. E.: J. Pediat. 44:386, 1954.

White, R. H. R., and Standen, O. D.: Brit. M. J. 2:755, 1953.

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Brown, H. W.: J. Pediat. 45:419, 1954.

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[1]Posner, A. C., *et al.;* Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.

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Distinguished Service Award
Of the Southern Medical Association

At the Houston meeting of the Southern Medical Association last November, a Distinguished Service Award was created by the Southern Medical Association. It was established for the purpose of recognizing a physician-member of the association for outstanding contributions to the advancement of medicine. Formerly a Research Medal had been awarded to 15 recipients since 1912 for work done only in the field of pure medical research.

Another purpose was to broaden the base of the scientific awards. The new award may be bestowed for outstanding and meritorious work performed in any field of medicine or its related and ancillary sciences. Outstanding achievement, therefore, in the broad fields of medicine, surgery, research and medical education, and in any of the medical and surgical specialties, comes within the scope of the Distinguished Service Award.

Any member of the association in good standing is eligible for nomination as a recipient of the award, and any member in good standing may nominate a candidate. An unpublicized committee evaluates the nominees, selecting three annually for submission to the Council. The Council then elects one of the three as the recipient. This choice is made during the annual meeting, and the successful nominee is publicly presented, if possible, during the last general session of the membership at a given annual meeting.

Those who wish to nominate a fellow-physician may obtain official forms from the association's headquarters. Surely this state has its share of candidates worthy of nomination. The first Distinguished Service Award is to be presented at the Golden Anniversary Meeting in Washington next month. Will a Florida candidate have a chance to win it? Certainly not, unless some colleague takes the trouble to nominate him.

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*Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 847.

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OTHERS ARE SAYING

Editorial

The apparently inexhaustible derivatives of the adrenal steroids appear now to promise eventual selective and possibly even single effects, permitting some day, perhaps, a degree of control over such things as salt and water balance or protein synthesis and storage. Already certain desired results may be obtained without deleterious cumulative multiglandular disturbances. Who does not recall the wonder of his first personal experience with the original corticotropins? It was much like handling nitroglycerine in its tricky just-about-to-explode liquid state. We were awed by its miraculous capabilities while doubting both our moral and our scientific qualifications for its use. Even now, with more experience to support us, we seldom prescribe even the "safer" corticoids without a vivid memory or two of the patients whose terminus may well have been hastened by our hopeful use of the earlier agents in this group.

The same spirit of cautious daring attended the brilliant accomplishments of the pioneers in anticoagulant therapy for thromboembolic disease, and all those who eventually faced the ultimate crisis of human testing regardless of the exact nature of their optimistic therapeutic or prophylactic project. The misery of active participation in some of the inevitable earlier untoward reactions, particularly those fatalities directly attributable to the innovations, must have been experienced to be believable. It should help to remember the thousands who have derived immeasurable benefit for each one who was exsanguinated from anticoagulants or died from multiple perforations while on steroid therapy for severe colitis, but sometimes it doesn't. It depends a lot on your proximity to and responsibility for one of those tough ones.

It's part of the job, of course, and neither wailing-walls nor crying towels would help us a particle. But it does seem that, in all humility, physicians might be a little slower to criticize each other. Certainly no one seeks a conspiracy of silence to protect or condone stupidity and bad faith, but where, if not to his brother practitioner, can one look for sympathy and understanding when he experiences the anguish of a bad result through factors apparently beyond his control?

Sedatives
A.) hypothalamic
Reserpine
B.) cortical
Mebaral

A.) Indications
1. Emotional instability
2. Anxiety
3. Tension states
a.) Premenstrual
b.) Menopausal
c.) etc.

B.) Treatment - Tranquilize!

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Let us be slow indeed to point the accusing finger, and quick to break the doubtful silence with a friendly word. As most of us know from our own experiences, it helps a lot.

—The Bulletin, Dade County Medical Association, June 1956

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Valentine Bloch, of North Miami, announce the birth of a son, Warren Edward, on July 5, 1956.

Dr. and Mrs. Bernard B. Vinoski, of Miami, announce the birth of a son, Bernard Jr., on July 19, 1956.

Dr. and Mrs. William Ingram Jr., of Jacksonville, announce the birth of a daughter, Louise O'Connell, on July 8, 1956.

Dr. and Mrs. Robert J. Brown, of Jacksonville, announce the birth of a son, Jonathan Judson, on July 27, 1956.

Marriages

Dr. James E. Kicklighter, of Sarasota, and Miss Mary Alice Eaton were married July 20, 1956, in Sarasota.

Deaths — Member

LeBreton, Prescott, Middletown, N. Y..... July 26, 1956

CLASSIFIED

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

MEDICAL OFFICE FOR LEASE: New Medical-Dental Arts Building. Air conditioned. Large waiting rooms. Very reasonable lease for the right medical doctors. Write H. W. Tustison, D.D.S., 1000 S. Federal Highway, Fort Lauderdale, Fla.

WANTED: Physician with Florida license. Interest in Physical Medicine and Geriatrics. State qualifications in writing. The Miami-Battle Creek, Miami Springs, Fla.

GENERAL PRACTITIONER: Wanted for group practice in Dade-Broward area. Write 69-194, P.O. Box 2411, Jacksonville, Fla.

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PHYSICIAN WANTED: Two General Practitioners, Pediatrician, E.E.N.T. (Board Member), and Psychiatrist to associate with a well established medical group in a rapidly growing central Florida East Coast area. Salary Open — depending on experience and training—with eventual partnership. Give complete personal and professional data in first letter. Florida license required. Write P.O. Box 57, Rockledge, Fla.

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integrated relief . . .
mild sedation
visceral spasmolysis
mucosal analgesia

TABLETS *(yellow, coated), each containing 50 mg. Trasentine® hydrochloride (adiphenine hydrochloride CIBA) and 20 mg. phenobarbital.*

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Summit, N. J.

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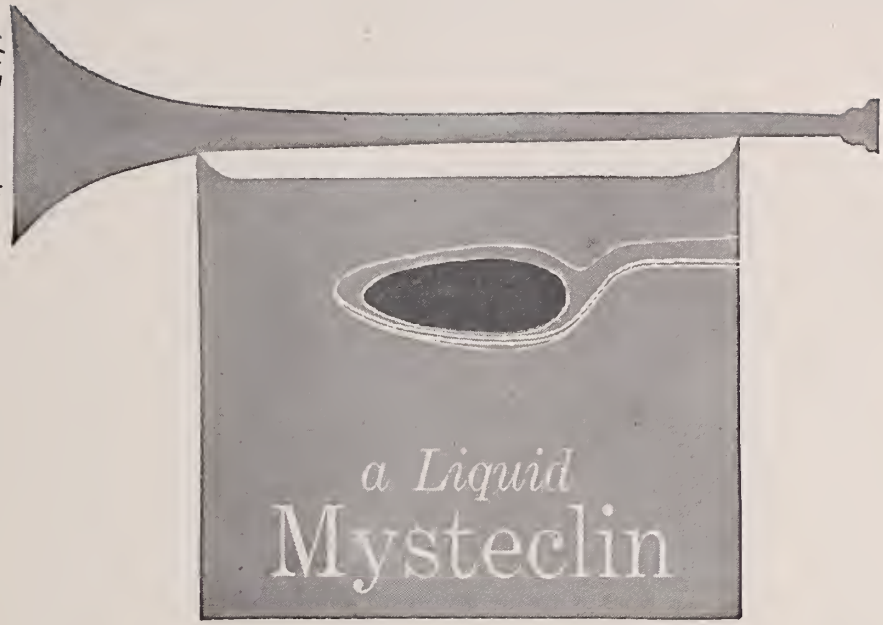

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Steclin-Mycostatin (Squibb Tetracycline-Nystatin)

Another form of the only broad spectrum antibiotic preparation with added protection against monilial superinfection

PLEASANT TASTING — Mysteclin Suspension is pleasantly fruit-flavored and will appeal to taste-conscious youngsters as well as to adults who prefer liquid medication.

BROADLY EFFECTIVE — Mysteclin Suspension provides well tolerated therapy for the many common infections which respond to tetracycline—and also acts to prevent monilial overgrowth.

READY-TO-TAKE — Mysteclin Suspension requires no reconstitution and can be given by simple teaspoon dosage to patients of all ages.

MYSTECLIN SUSPENSION: a fruit-flavored oil suspension containing the equivalent of 125 mg. Steclin (Squibb Tetracycline) Hydrochloride and 125,000 units Mycostatin (Squibb Nystatin) per 5 cc. teaspoonful. Supplied in two-ounce bottles.

Also available as Capsules (250 mg. Steclin Hydrochloride and 250,000 units Mycostatin) and Half Strength Capsules (125 mg. Steclin Hydrochloride and 125,000 units Mycostatin).

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KARO® SYRUP . . . meets the accelerated nutritional requirement of early infancy

The high caloric requirements of infants, coupled with the fact that they have little ability to digest starchy food, are indications for the use of an easily digested carbohydrate milk modifier.

Karo places a minimum demand upon the digestive system during the first weeks of life. Even premature babies thrive on Karo because this easily digested, completely utilized, fluid mixture of dextrins, maltose and dextrose does not induce flatulence, colic, fermentation or allergy.

Karo permits easy adjustment of formula to meet the accelerated nutritional demand during the early months of rapid growth. Mothers will appreciate the ease of making formulas containing Karo, plus its ready availability and economy. Light or dark Karo syrup may be used interchangeably with cow's milk or evaporated milk and water. Each ounce yields 120 calories.

1906 • 50th ANNIVERSARY • 1956
CORN PRODUCTS REFINING COMPANY
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KNOX Protein Previews

New Study Shows Gelatine Restores Brittle Fingernails to Normal

Directions for making the Knox Gelatine drink in every package

Brittle, fragile or laminating fingernails are the bane of many a woman's existence. Yet this highly prevalent and distressing condition often has gone uncontrolled for lack of effective therapy. Now, you can promise these patients substantial relief in a large percentage of cases.

In a recent study[1] that confirmed previous work[2] Knox Gelatine was used to treat 36 women with fragile, brittle, laminating fingernails. The response was most gratifying. Except for three patients who discontinued the therapy, three diabetics, and two women who had congenital deformities, the splitting ceased and all other patients were able to manicure their nails to a full point by the time the study ended.

Optimal dosage proved to be one envelope (7 grams) of Knox Gelatine administered daily for three months. Efficacy has not been established with lesser dosage. If you would like more complete details of this work, just use the coupon.

1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* 19:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* 14:323, May 1950.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Dept. SJ-19
Johnstown, N. Y.

Please send me a reprint of the article by Rosenberg and Oster with illustrated color brochure.

YOUR NAME AND ADDRESS

Most people are able to talk freely to their physician about every aspect of their treatment—*except one*. The question, "How much is it going to cost?" and of how payment is to be made, often leaves the frankest patient tongue-tied.

Many refrain from bringing up the subject out of a sincere respect for their doctor, supposing it somehow unbecoming to talk to him about money. Many professional societies are now trying to clear up this misconception. For example, you may have noticed a significant plaque which hangs in thousands of physicians' waiting rooms. It says:

"To all my patients — I invite you to discuss frankly with me any questions regarding my services or fees. The best medical service is based on a friendly mutual understanding between doctor and patient."

Sometimes, of course, your doctor cannot tell you, in advance, precisely what a course of treatment or an operation is going to cost. But you will always find him willing to discuss the subject, and to tell you if he can. Today more than ever before in medical history, the bill your doctor sends you can represent one of the really big bargains of your life — in terms of health, happiness and peace of mind.

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Research and Manufacturing Laboratories, Detroit 32, Michigan

Makers of medicines since 1866

Doctor, you have probably seen one or more of these current Parke-Davis advertisements in leading general magazines—and you know that the much-talked-about theme of these ads is that *prompt and proper medical care is one of today's biggest bargains.* Through our sales representatives who call on you, and your letters to us, we know that this is the type of laity advertising *you* like to see.

The reproduction on the facing page is the latest example of this advertising. It tells the public that they can discuss medical fees with their physicians without embarrassment . . . and that such discussions improve the important relationship between doctor and patient.

We are gratified at your response to these public messages, and you can be sure that Parke-Davis national advertising will continue to be in our *mutual* best interests.

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Detroit 32, Michigan

Reaching millions of people in LIFE, POST, TODAY'S HEALTH and other leading magazines

STATE NEWS ITEMS

Dr. Frederick K. Herpel of West Palm Beach, a past president of the Florida Medical Association, has returned from an extensive two month trip abroad where he visited various hospitals and clinics. Included in the tour were the countries of Scandinavia, Denmark, Sweden and Norway.

Dr. Robert G. Nelson of Tampa is section chairman for Florida and Dr. Ralph W. Jack of Miami vice chairman for the clinical meeting of the American College of Obstetricians and Gynecologists being held at the Palmer House in Chicago on November 7-9, 1956.

A gift of $9,000 has been received by the University of Florida College of Medicine from the Smith, Kline and French Foundation of Philadelphia. The fund is to be used in support of medical research.

The Florida Alcoholic Rehabilitation Center and 50 bed specialized hospital of the Florida Alcoholic Rehabilitation Program located at Avon Park is scheduled for admission of patients before January, 1957.

Dr. James N. Patterson of Tampa has returned from Boston and New York. In Boston he attended the International Congress on Hematology and the meetings of the International Society of Blood Transfusions and the American Association of Blood Banks. He was in New York for the International Congress on Hemophilia.

The new national headquarters building of the American Academy of General Practice at Kansas City, Mo., has been formally dedicated. The principal speaker for the occasion was Dr. Dwight H. Murray of Napa, Calif., president of the American Medical Association.

Dr. George F. Schmitt Jr. of Miami has been appointed to the Medical Advisory Board of The Mayo Foundation; the Pan American Committee of the American Rheumatism Association, and to the Scientific Exhibit Committee of the American Diabetic Association.

The National Foundation for Infantile Paralysis has announced the availability of fellowships for full time study in preparation for careers in

(Continued on page 388)

Anderson Surgical Supply Co.

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ORAL PENICILLIN FOR *BETTER* AND *MORE CONSISTENT* ABSORPTION

"Because of the better and more consistent absorption of penicillin V from the intestinal tract, it would appear that this type of penicillin is preferable to penicillin G when oral administration is to be used."[1]

1. Martin, W. J., et al.: J.A.M.A. *160*:928 (March 17) 1956.

PEN•VEE•*Oral* and PEN•VEE *Suspension* permit new dependability in oral-penicillin therapy—dependable stability in gastric acid, dependable and optimal absorption in the duodenum. "Not being destroyed by acid in the stomach, as is penicillin G, penicillin V remains available in larger amounts for absorption."[1]

PEN·VEE* *Oral* and *Suspension*

PEN•VEE•*Oral* is Penicillin V, Crystalline (Phenoxymethyl Penicillin)
PEN•VEE *Suspension* is Benzathine Penicillin V Oral Suspension

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NEW

ATARAXOID is a unique, new combination of STERANE and ATARAX, which now permits simultaneous symptomatic control and reduction of attendant anxiety and apprehension in rheumatoid arthritis and other indications.

The added tranquilizer control, desirably easing mental stress, also directly assists clinical progress. It minimizes the chance of exacerbation related to emotional strain and facilitates patient confidence and cooperation in the therapeutic program toward maximum rehabilitation.

ATARAXOID exerts the anti-rheumatic, anti-inflammatory activity of STERANE distinctly superior to previous steroids, effective in radically reduced dosage, and with minimal disturbance of electrolyte and fluid metabolism.

The ataractic effect is a central neuro-relaxing action – the result of a marked cerebral specificity – free of mental fogging and devoid of any major complications: no liver, blood or brain damage. This peace-of-mind component is also used in the lowest dosage range.

Supplied: Each green, scored, ATARAXOID oral tablet contains 5 mg. prednisolone (STERANE) and 10 mg. hydroxyzine hydrochloride (ATARAX). Bottles of 30 and 100.

PFIZER LABORATORIES
Division, Chas. Pfizer & Co., Inc.
Brooklyn 6, New York

the first and only ataraxic-corticoid

araxoid*

prednisolone and hydroxyzine

Pfizer

combining the newest, safest tranquilizer, ATARAX® + the newest, most effective steroid, STERANE® (prednisolone)

simultaneously controls the symptoms and the apprehension

In Rheumatoid Arthritis, other collagen diseases, bronchial asthma and inflammatory dermatoses

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(Continued from page 384)

research, academic medicine, or in the clinical fields of psychiatry, rehabilitation, orthopedics, or in the management of poliomyelitis and preventive medicine. Particulars may be obtained from the Division of Professional Education. The National Foundation for Infantile Paralysis, 120 Broadway, New York 5.

Dr. Richard F. Sinnott of Ft. Pierce has been elected a director of the Chamber of Commerce for that city.

Dr. Lawrence E. Geeslin of Jacksonville discussed atherosclerosis at a recent meeting of the Jacksonville Junior Chamber of Commerce.

Drs. John A. Mease Jr. and James F. Spindler of Dunedin have returned from Mexico City where they attended the Eighth International Congress of Radiology held in the Auditorio Nacional.

Dr. Jacob A. Glassman of Miami, assistant clinical professor of surgery at the University of Miami School of Medicine, is scheduled to address the One Hundred Sixth Annual Meeting of the Medical Society of the State of Pennsylvania on Thursday afternoon, October 25. Dr. Glassman's subject will be "The Re-evaluation of Breast Carcinoma and Its Management."

Drs. Hugh A. Carithers and J. Champneys Taylor of Jacksonville served on the faculty of the Southern Pediatric Seminar held recently at Saluda, N. C.

Dr. Harold S. Kaufman of Miami Beach has returned from Los Angeles, Calif., where he has completed a postgraduate course in surgery at the University of Southern California, School of Medicine.

Dr. James M. Davis of Jacksonville has been certified a diplomate of the American Board of Thoracic Surgery.

Dr. Herman Glassman of Miami has been visiting clinics and various medical centers in England and other countries of Europe.

Dr. John B. Ross of Jacksonville has returned from Boston where he attended meetings of the International Congress on Hematology and the International Society of Blood Transfusions.

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Every ATLAS injectable is manufactured in our own new, ultra-modern laboratory under strictest controls. Continued research and testing assures the finest standard injectables as well as distinctive new formulae as they are perfected... Potencies and purity guaranteed, yet a realistic pricing policy makes them readily usable in every case.

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established
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(phenylbutazone GEIGY)

potent, specific anti-arthritic

Based on an impressive background of achievement attained over a period of four years involving both long-term and short-term therapy in all the major forms of arthritis, BUTAZOLIDIN is recognized as one of the most effective anti-arthritic agents currently available.

relieves pain
improves function
resolves inflammation

BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for literature before prescribing it.

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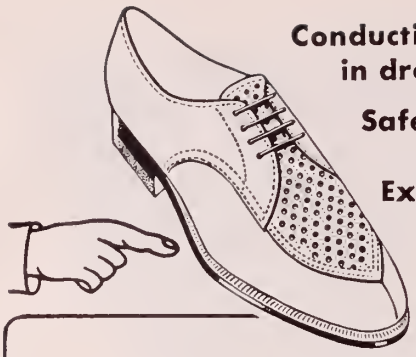

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Safety from Fire and Explosion★

- Insole extension and wedge at inner corner of heel where support is most needed.
- The patented arch support construction is guaranteed not to break down.
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★ Conductive Shoes for surgical and operating room personnel. N.B.F.U. specifications.

- We are also the manufacturer of the Gear-Action Shoe designed by noted orthopedic surgeon.
- We make more shoes for polio, club feet and disabled feet than any other shoe manufacturer.

Send for free booklet, "The Preservation of the Function of the Foot Balancing and Synchronizing the Shoe with the Foot."

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"Patients without primary renal disease, but with albuminuria and high nonprotein nitrogen due to congestive circulatory changes, can be adequately and safely treated with Neohydrin for long periods of time."*

*Griffith, G. C.; Dimitroff, S. P., and Thorner, M. C.: Ann. Int. Med. 45:7, 1956.

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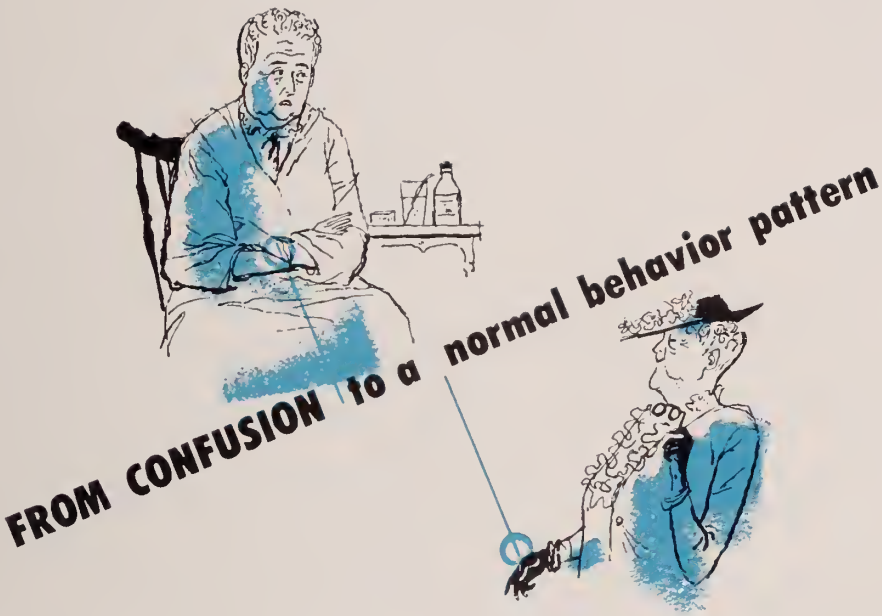
Register and Vote Campaign

An Uninformed Vote is as Bad or Worse than no Vote at All

Next month, on Tuesday, November 6, it will be the privilege of every *Registered Voter* in our nation to go to the polls in his or her precinct and vote for those believed to be best qualified for the public offices. This privilege we should treasure above all others, for it is the perfect demonstration of our real freedom. The voting booth is *yours* and no one but you will know how you voted — something that has always been rare in this world but something which has become more of a rare privilege following World War II as we have seen dictatorial countries take over more and more peoples and have control of all government offices from dog catcher up to the top government office.

However to go into the voting booth uninformed on how men think and how they stand on the fundamental principles of our freedom and to cast a vote for one man or another simply because we like his looks or because he makes an attractive appearance on television, or because we



NICOZOL
relieves mental confusion and deterioration, mild memory defects and abnormal behavior patterns.

NICOZOL *for senile psychoses*

REHABILITATION and RELEASE
from public and private psychiatric institutions for the mildly confused and mildly deteriorated aged patients may be accomplished by treatment with the NICOZOL formula. 1-2-3

NICOZOL IS SUPPLIED
in capsule and elixir forms.
Each capsule or ½ teaspoonful of elixir contains:
Pentylenetetrazol —— 100 mg.
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1. *Levy, S.* J.A.M.A. *153:1260, 1953.*
2. *Thompson, Lloyd & Proctor, Rich.* N. C. State, *Dec. 54*
3. *Thompson & Proctor,* Clinical Med. *April, 1956*

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P. O. Box 830, Winston-Salem, N. C.
Kindly send me professional sample of NICOZOL Capsules, also literature on NICOZOL for senile Psychoses.

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know someone who knows him, or because he came from the old alma mater, or for whatever reason other than the worth of the man and his fundamental principles — our vote is an uninformed vote based on false premises when it comes to his ability to serve our country, our state or our county to the benefit of all the people and as the servant of all the people, not as their master.

Far be it from us to tell you *Whom to Vote For* but we do believe we may make some suggestions on *How to Make up Your Mind Whom to Vote For.* In two words, *Be Informed.*

1. If the candidate has been in office before, how did he vote during that term of office on various bills affecting the real welfare of the people? Real welfare has nothing to do with economic welfare alone but has to do with the morale and sound faith of a people as well — not just their economic betterment. Did he vote for the good of all of the people?

2. As a doctor and a doctor's wife, those of us from the medical association or auxiliary should be informed of the votes on other than medical measures. A well rounded knowledge of the man's actions on legislative problems makes us better informed in deciding for whom to vote.

3. Many of our candidates will be new to the field of politics and should not be excluded from our thinking because they have no public record behind them. What did they do to prepare themselves for public office, what was their work prior to entering the campaign, what has been their reputation for honesty, decency, community service prior to their entering into politics?

4. Who are the men who are working for their election? If their workers and the managers of their campaigns are men who have had self-seeking, political climbing reputations in the past, one can be sure that those who advocate that man for public office intend to use him after he is in office.

There is something else to this privilege of voting without fear and without favoritism that is a very necessary part of the picture. That is that every qualified citizen be a *Registered Voter.* Unless one is registered, he cannot vote and *your vote is needed.*

During the past few years, many new doctors and their wives have moved into Florida. Do you know for sure that all of them are registered voters? If not, we all have a responsibility, yes, and a privilege, of seeing that they are registered

(Continued on page 402)

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Q: *In x-ray equipment what will $4950 buy?*

A: This new G-E PATRICIAN

complete with 200-ma control and transformer

YOURS . . . General Electric quality . . . complete diagnostic x-ray unit with tilt table . . . combined facilities for fluoroscopy and radiography—all for just $4950, f.o.b. Milwaukee, U.S.A.

New PATRICIAN gives you 81-inch angulating table . . . independent tubestand with choice of floor-to-ceiling or platform mounting . . . 200-ma, 100-kvp, full-wave transformer and control . . . double-focus, rotating-anode tube.

Also, you get counterbalanced automatic Bucky, plus fluoroscopic screen that's also counterbalanced, self-retaining in all table positions. You can take cross-table and stereo views. Focal-film distances range up to a full 40 inches at any table angle . . . as great as 48 inches cross-table.

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resistant

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METRETON tablets

METICORTEN (PREDNISONE) PLUS CHLOR-TRIMETON WITH ASCORBIC ACID

For prompt and effective relief, especially in many resistant allergic disorders, METR affords the benefits of two established agents with unexcelled anti-inflammatory, a allergic and antipruritic effectiveness. *supported by essential vitamin C*—for s support and for postulated effect on prolonging steroid action *no better corticoste* —original brand of prednisone...minimal electrolyte effects—METICORTEN *no better a histamine*—unexcelled in potency and freedom from side effects—CHLOR-TRIM effective against hay fever, pollen asthma, perennial rhinitis, acute and chronic urtic angioneurotic edema, drug reactions, inflammatory and allergic eye disorders, pru and contact dermatoses.

formula: Each tablet of METRETON provides 2.5 mg. of METICORTEN (prednisone), 2 mg. of CHLOR-TRIM maleate (chlorprophenpyridamine maleate), and 75 mg. ascorbic acid.

supplied: METRETON Tablets, bottles of 30 and 100.

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METRETON *nasal spray*

METICORTELONE (PREDNISOLONE) PLUS CHLOR-TRIMETON

quickly clears nasal passages • avoids rebound engorgement and sympathomimetic side effects • safe even for cardiacs, hypertensives, children, pregnant patients •

Composition: Contains 2 mg. (0.2%) METICORTELONE acetate (prednisolone acetate) and 3 mg. (0.3%) of CHLOR-TRIMETON gluconate (chlorprophenpyridamine gluconate) in each cc.

Packaging: 15 cc. plastic "squeeze" bottle, box of 1.

METRETON,* brand of corticoid-antihistamine compound; METICORTEN,* brand of prednisone; METICORTELONE,® brand of prednisolone; CHLOR-TRIMETON,® brand of chlorprophenpyridamine preparations. *T.M.

MT-J-576

Schering

With little chance of error in Formula Preparation

BAKER'S MODIFIED MILK*

Feeding Directions

Baker's Modified Milk (Liquid)

(Normal dilution for liquid provides 20 calories per liquid ounce.)

	Baker's	Boiled Water
Hospital	1 part	2 parts
First week at home	1 part	1½ parts
After first week at home	1 part	1 part

Also available in powder form. Normal dilution one tablespoon to 2 ounces of water provides 20 calories per fluid ounce.

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Imagination is essential in adding interest to this diet since your patient may have to follow it for many years. These diet "do's" can show him how to use eggs, cheese, and milk—a trio of almost purine-free foods—to supply the major portion of his protein.

In these, the trio plays a solo—

Eggs baked in pimiento-flecked cheese sauce are hard to resist. Or, if your patient prefers, the same gay and tempting sauce can be poured over hard-cooked eggs.

A casserole of eggplant and tomatoes layered alternately with ricotta or cottage cheese makes a satisfying entree. Add a sprinkle of grated parmesan with a fine Italian hand.

Your patient may like his eggs poached in tomato juice. Serve them in a soup bowl with a frill of chopped parsley on top.

In these, the trio plays accompaniment—

Ham 'n' egg rolls come hot or cold. For hot, roll a warm slice of ham around eggs that have been scrambled with a pinch of savory. For cold, roll a ham slice around egg salad mixed with cottage cheese.

Oyster stew can be creamy without cream when the milk is bolstered with dry skim milk powder. A pinch of thyme and some chopped parsley add savor.

Broiled salmon or tuna-burgers nestle nicely in a nest of noodles. A slice of cheese on top adds color and comes out of the broiler a bubbling brown.

These are only a few of the possible combinations of this versatile trio. And the adequate protein nutrition they make possible, plus a liberal intake of fluids—including beer* if your patient's condition allows—may help establish a regimen that will please you both.

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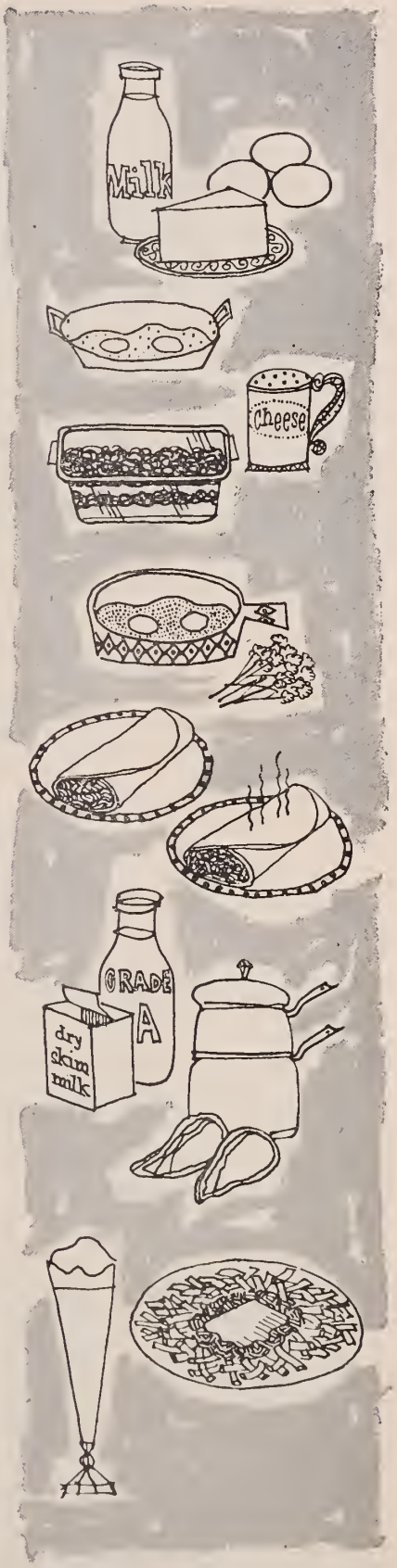
Beer — America's Beverage of Moderation

*104 Calories, 17 mg. Sodium/8 oz. glass (Average of American Beers)



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1. Cronheim, G., and Tockes, I. M.; Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures. Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.
2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. *96*:530 (Oct.) 1955.

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to minimize gastric distress

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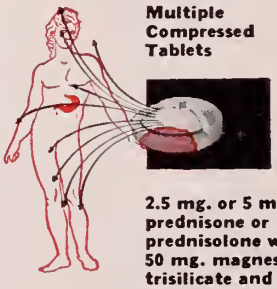

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(Buffered Prednisolone)

2.5 mg. or 5 mg. prednisone or prednisolone with 50 mg. magnesium trisilicate and 300 mg. aluminum hydroxide gel.

Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* 158:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* 158:459, (June 11,) 1955.

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in bronchial asthma

clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of the "predni-steroids" antacids should be routinely co-administered to minimize gastric distress

ROUTINE CO-ADMINISTRATION MEANS

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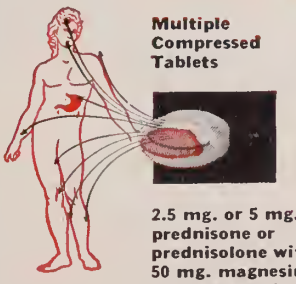

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All the benefits of the "predni-steroids" plus positive antacid action to minimize gastric distress.

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(Continued from page 392)

voters and that their ballots are cast this November for national, state and county officers. This is one responsibility that repeats itself every year — that of seeing that all our members are registered to vote and that they do vote.

Your auxiliary stands ready to help in seeing that this responsibility is met. Your auxiliary can check the voting list and remind those who are not registered that they should go and register immediately so that their vote can be cast on November 6. Your auxiliary can and will call the medical association members and their wives on election day to remind them that *voting is a must.* Please ask their cooperation in seeing that we accept our responsibility and our privilege of casting our ballots on election day, November 6.

May we suggest that each individual doctor, his wife and those of his family who can be registered voters do the following:

Register to Vote Now. This is a must in being a responsible and good citizen in your country.

Inform yourself on Issues and Men. Remember that an uninformed vote, be it for president or dog catcher, is as bad or worse than no vote at all.

Vote on November 6. This is your privilege in our free country but to keep it free you must exercise your privilege of voting, and being informed ahead of time on each person running for office. Don't stop with casting your vote for just the president of the United States—CAST YOUR VOTE FOR EVERY OFFICE.

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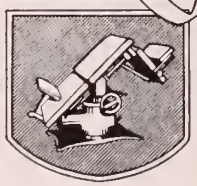

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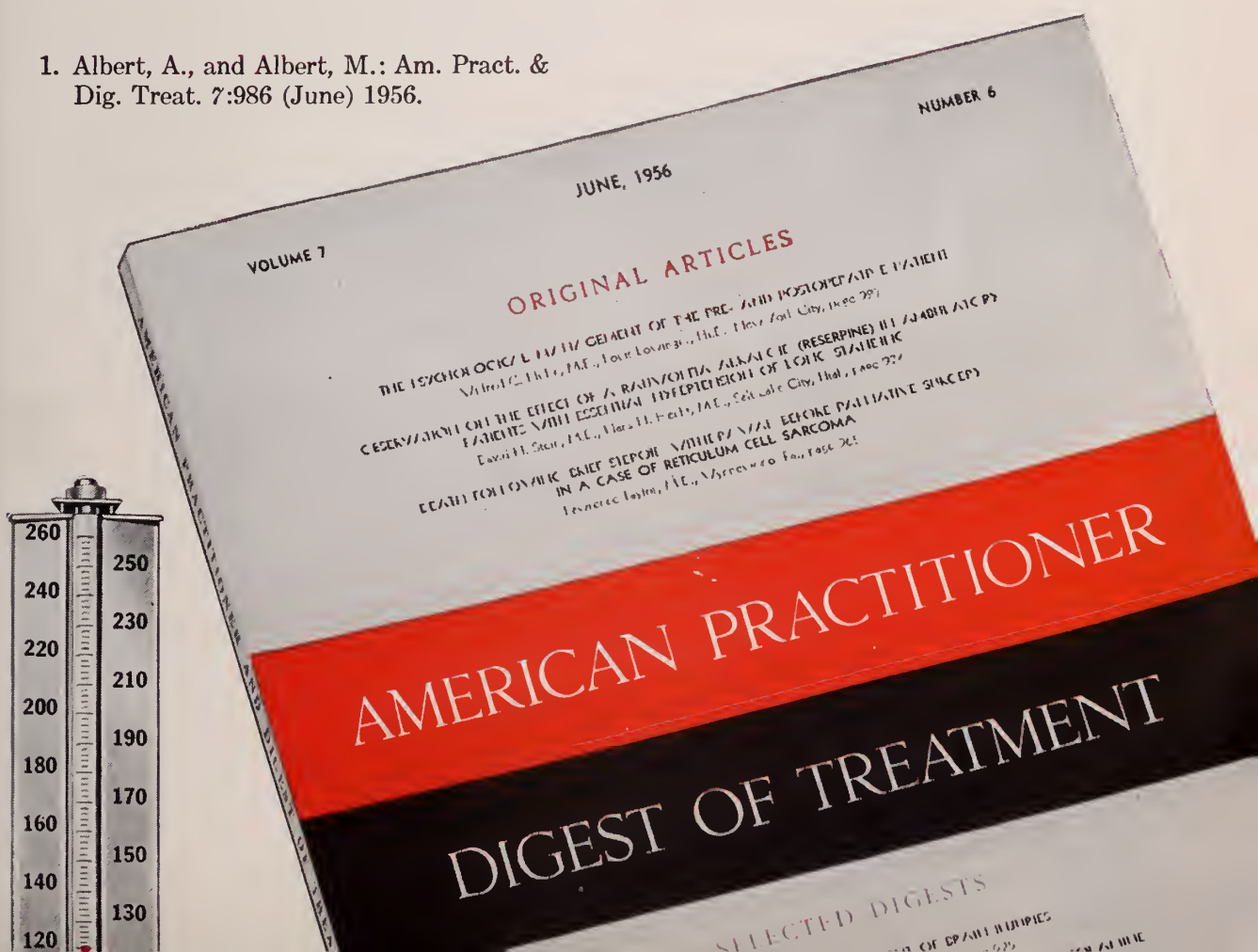
1. Albert, A., and Albert, M.: Am. Pract. & Dig. Treat. 7:986 (June) 1956.



Erythromycin in the treatment of osteomyelitis

8/3/55

CASE SUMMARY

On 6/2/55, patient, male, age 28, fell on an old fracture and refractured the middle third of the right femur, superimposed on an old osteomyelitis.

On 7/7/55, the wound was saucerized and a hemolytic S. aureus (coag. +) was isolated from the osteomyelitis. Disc sensitivities were: penicillin, 10 units; erythromycin, 10 mcg.; tetracycline, 10 mcg.

On 7/15, the patient was placed on erythromycin therapy 400 mgm. q. 6. h. Patient afebrile after erythromycin started. X-rays showed evidence of healing with callus formation. No septicemia and clinical evidence indicates control of the infection.

On 8/3, the cast was removed and leg recast. Wound was in good condition with minimal drainage.

Diagnosis: fracture middle third of right femur, complicated by osteomyelitis.

Result: erythromycin aided healing of the old osteomyelitis and kept the infection under control.

* *Communication to Abbott Laboratories*

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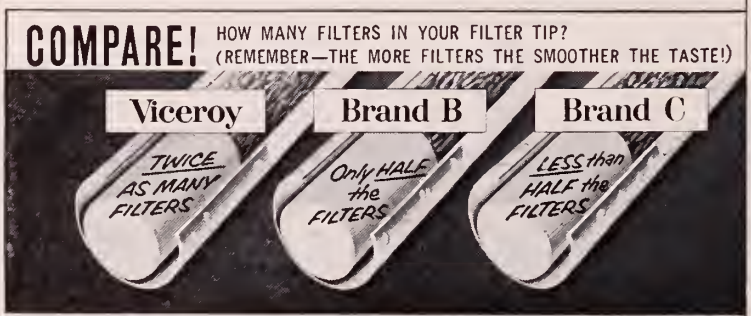

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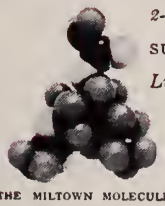

THE MILTOWN MOLECULE

"You try to scrub the bathtub with your back aching morning till night!"

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"That's nothing. I went around with my arm in a sling for nearly two weeks—had to sleep with a pillow at my back so I wouldn't roll over on it."

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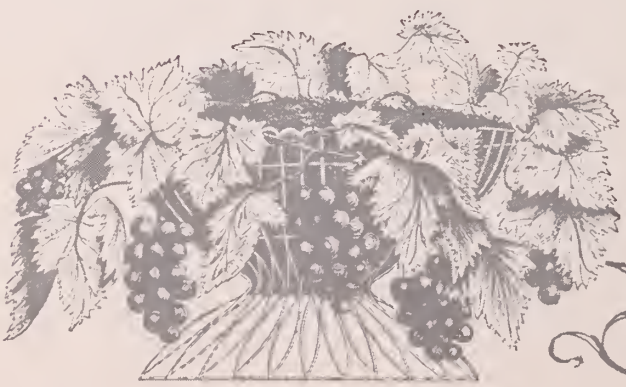

May we send you a copy of "Uses of Wine in Medical Practice." Just write to: Wine Advisory Board, 717 Market Street, San Francisco, California.

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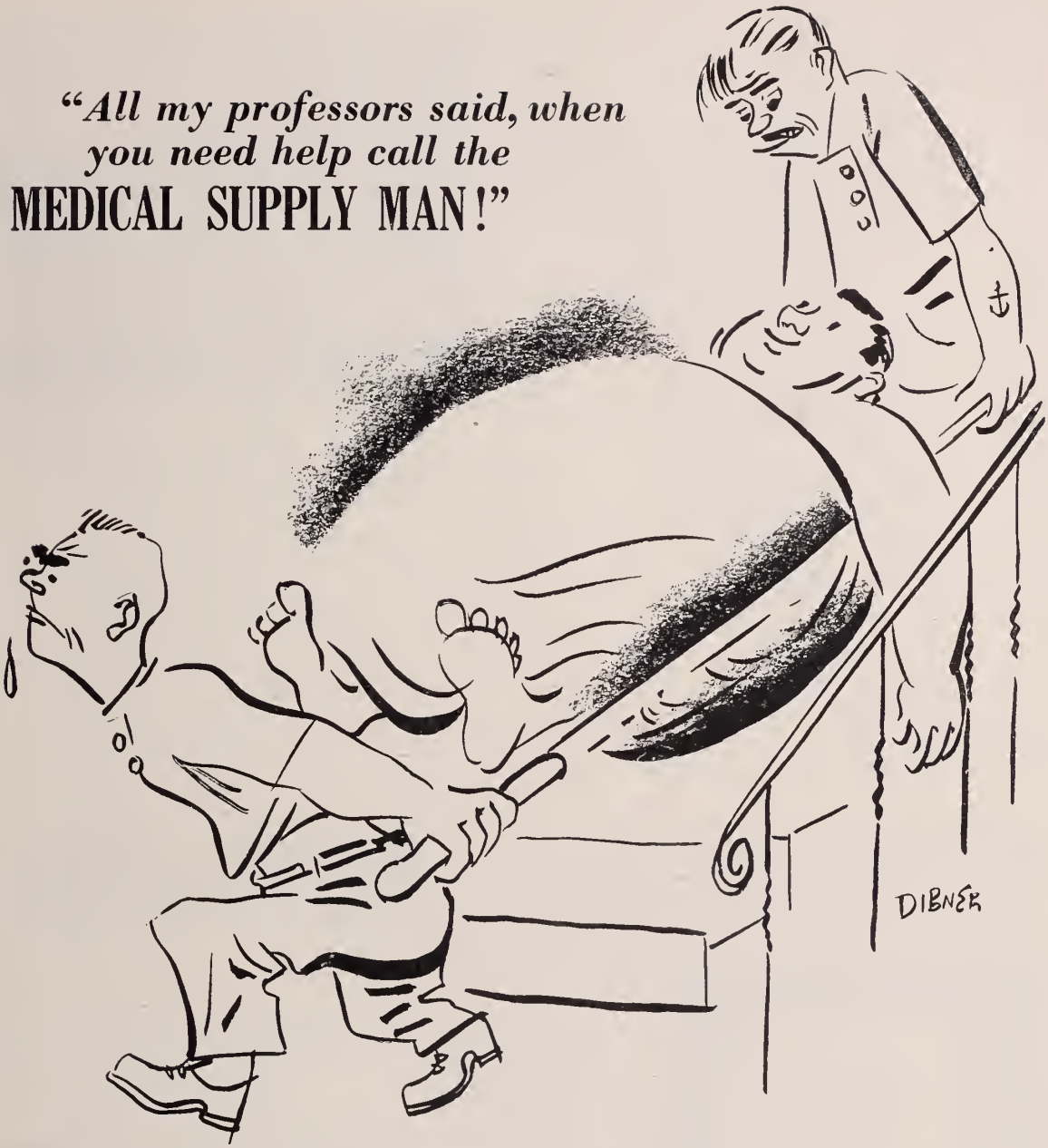

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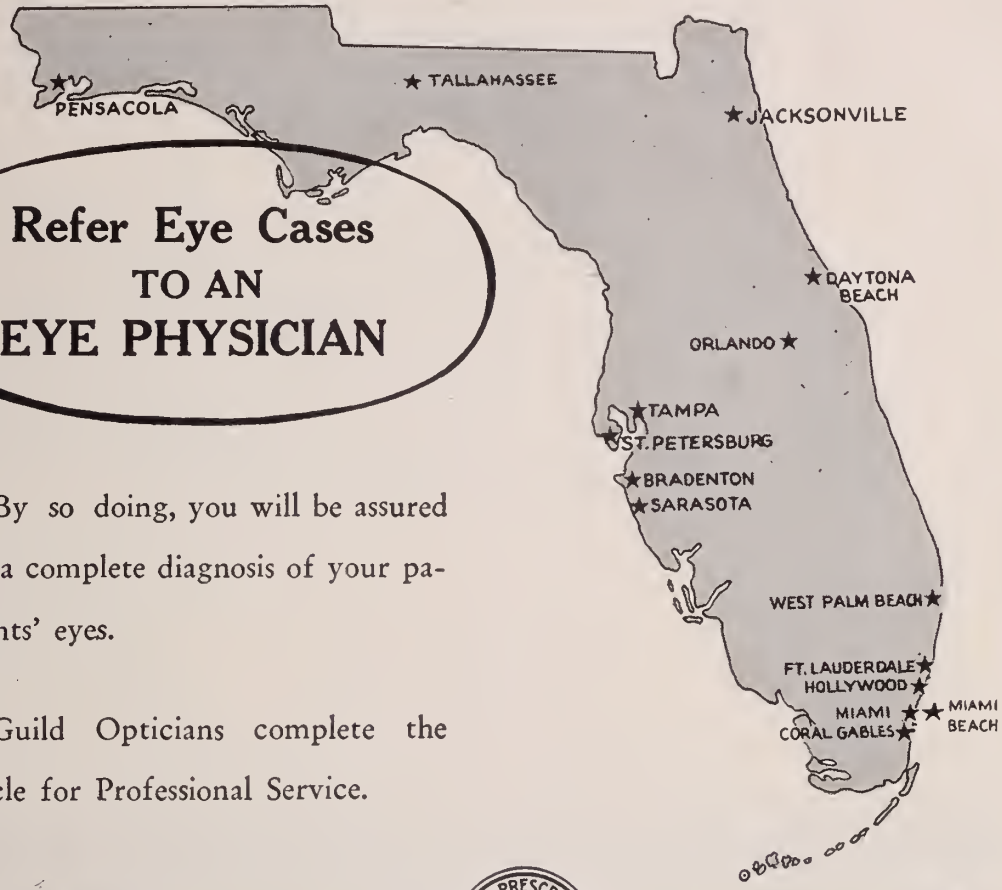

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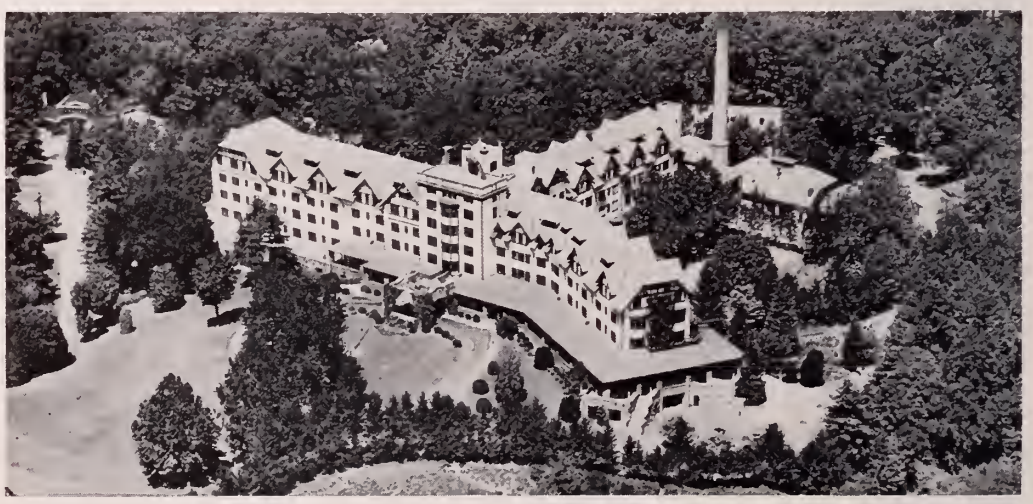

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la Specialty Societies			
emy of General Practice	Leo M. Wachtel Jr., Jacksonville	Charles D. Cooksey, Jacksonville	Jacksonville, Oct. 20-21, '56
y Society	Edwin P. Preston, Miami	Harold Rand, Miami	Hollywood, May 5, '57
hesiologists, Soc. of	Harry E. Bierley, W. Palm Bch.	Edwin C. Northup, St. Petersburg	" " " "
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logy & Psychiatry	Paul S. Jarrett, Miami	J. Robert Campbell, Tampa	Nov., 1956
nd Gynec. Society	S. L. Watson, Lakeland	T. Bert Fletcher, Jr., Tallahassee	Dec. 1-2, '56
nal. & Otol., Soc. of	Blackburn W. Lowry, Tampa	Kenneth S. Whitmer, Miami	Jan., 1957
pedic Society	Newton C. McCollough, Orlando	Harry E. Beller, Miami	Oct., 1956
logists, Society of	Wray D. Storey, Tampa	Clarence W. Ketchum, Tallahassee	Hollywood, May 5, '57
tric Society	Wesley S. Nock, Coral Gables	Henry G. Morton, Sarasota	Clearwater, Nov. 1-4, '56
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ican Medical Association	Dwight H. Murray, Napa, Calif.	Geo. F. Lull, Chicago	New York, June, 1957
M.A. Clinical Session			Seattle, Nov. 27-30, '56
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eastern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	
eastern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	
Coast Clinical Society	E. T. McCafferty, Mobile, Ala.	Theo. Middleton, Mobile, Ala.	Mobile, Ala., Oct. 18-19, '56

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Bay	Joseph H. Morris, Panama City	John J. Hollomon Jr., Panama City	1st Tues.	30
Brevard	Isabel Roberts, Melbourne	Jack T. Bechtel, Eau Gallie	2nd Tues.	42
Broward	Thomas F. Huey Jr., Fort Lauderdale	Anthony C. Galluccio, Hollywood	4th Tues.	144
Columbia	Thomas H. Bates, Lake City	Clifton G. York, Lake City	1st Mon.	11
**Baker*				
Dade	Hunter B. Rogers, Miami	Vincent P. Corso, Miami	1st Tues.	768
DeSoto-Hardee-Highlands-Glades	Merle C. Kayton, Wauchula	Roland W. Banks, Wauchula	1st Tues.	27
Duval	Joseph J. Lowenthal, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	315
**Clay*				
Escambia	Gretchen V. Squires, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	104
**Santa Rosa*				
Franklin-Gulf	Harold B. Canning, Wewahitchka	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	James N. Patterson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	203
Indian River	Vernon L. Fromang, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	10
Jackson-Calhoun	Richard H. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	18
Lake	Geoffrey H. Binneveld, Leesburg	J. Basil Hall, Tavares	1st Wed.	34
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Leon-Gadsden-Liberty-Wakulla-Jefferson	Robert H. Mickler, Tallahassee	Odis G. Kendrick Jr., Tallahassee	Quarterly	71
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Marion	William J. McGovern, Ocala	Robert L. Gibson, Ocala	3rd Tues.	32
**Levy*				
Monroe	Allen Shepard, Key West	William R. Ploss, Key West	1st Thurs.	13
Nassau			Last Fri.	9
Orange	Thomas C. Butt, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	201
**Osceola*				
Palm Beach	Walter R. Newbern, West Palm Beach	Horace D. Atkinson, West Palm Beach	4th Mon.	151
Pasco-Hernando-Citrus	Gail M. Osterhout, Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	17
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Seminole	William V. Roberts, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	Shirley L. Hadden, Live Oak	Hiram B. Curry, Jasper	1st. Sat.	12
**Hamilton, Lafayette*				
Taylor	Ralph J. Greene, Perry	John H. Parker Jr., Perry	Last Fri.	5
**Dixie*				
Volusia	Theodore F. Hahn Jr., DeLand	Achille A. Monaco, Daytona Beach	2nd Tues.	89
**Flagler*				
Walton-Okaloosa	Henry C. White Jr., Fort Walton Bch.	George W. Barrow Jr., Crestview	3rd Tues.	22
Washington-Holmes	Martin L. Lane, Chipley	L. H. Paul, Bonifay		4
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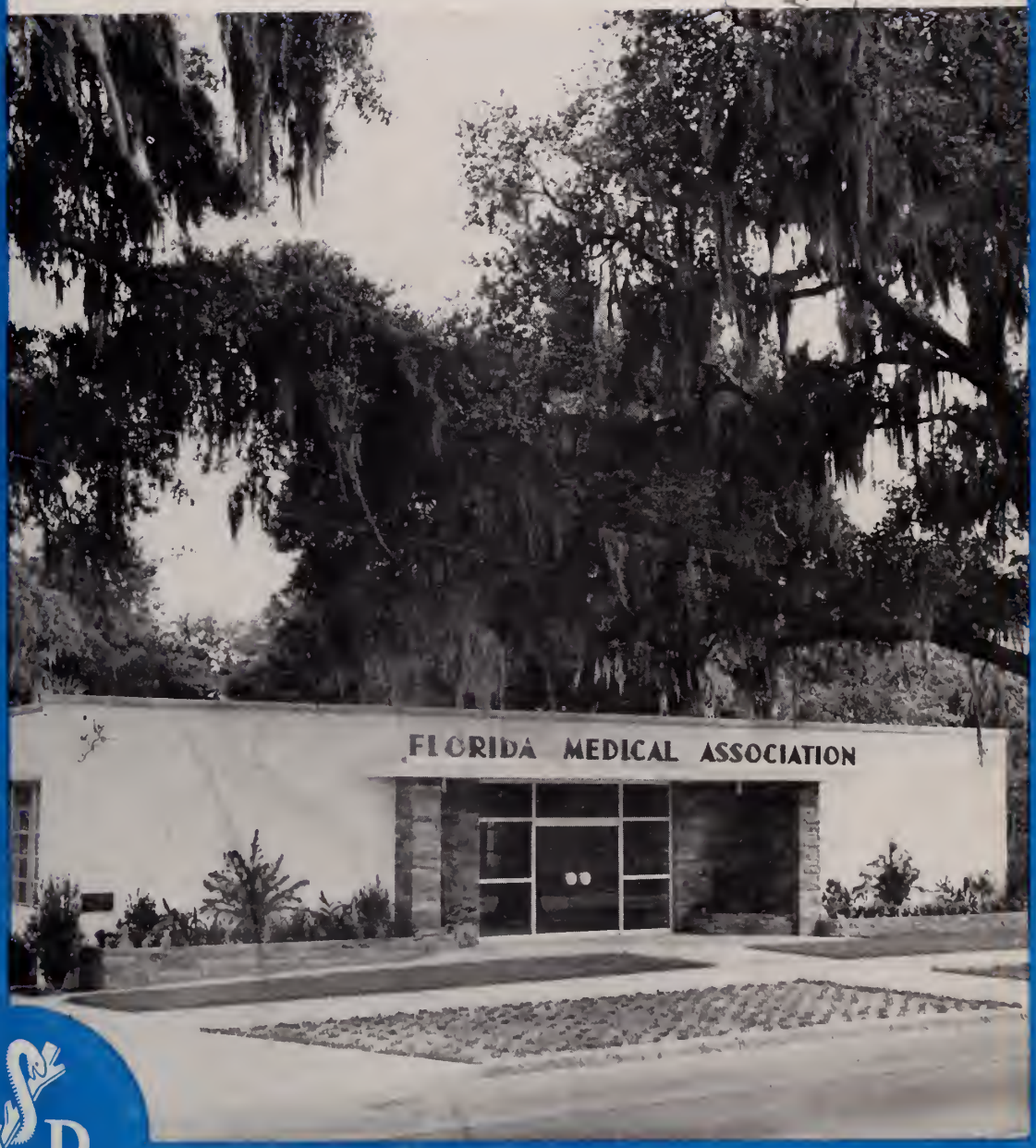
Vol. XLIII NOVEMBER, 1956 No. 5



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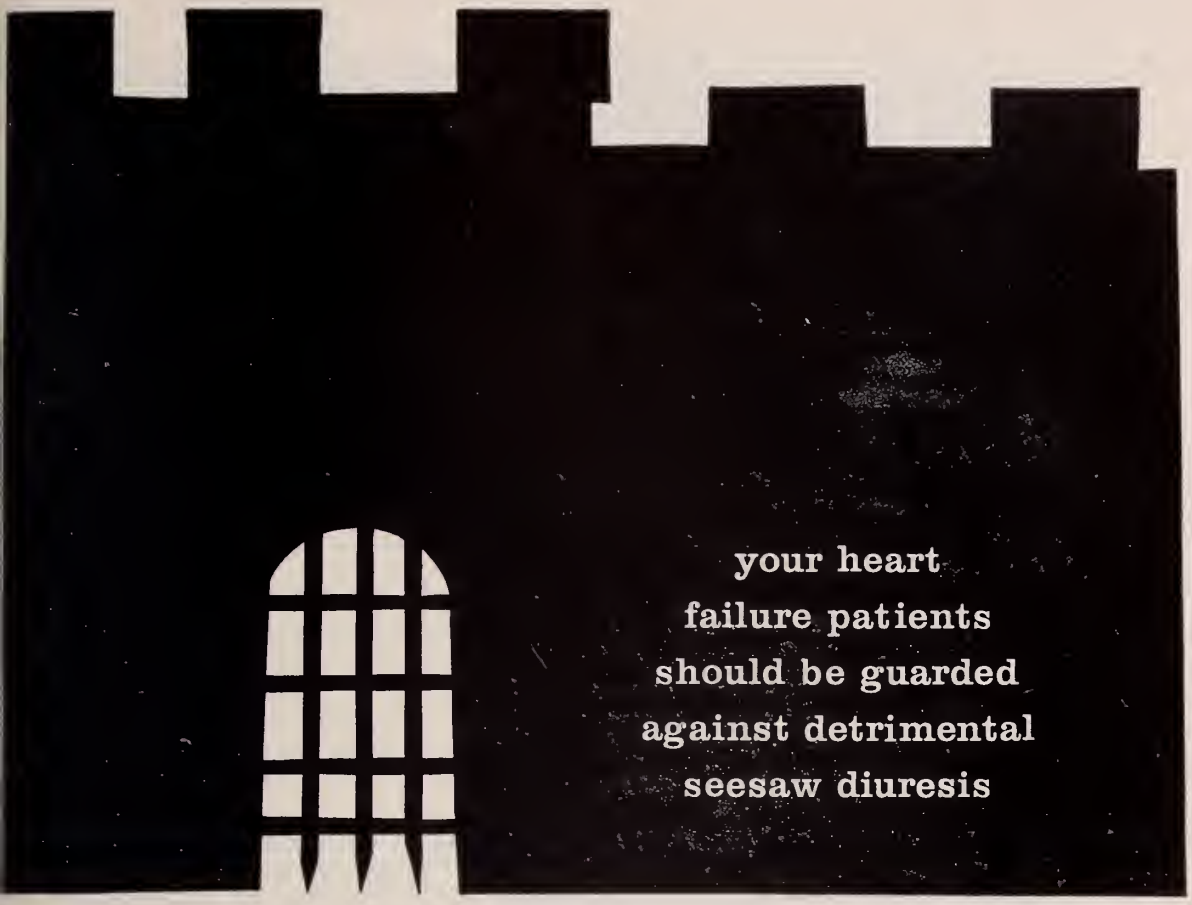

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1. Mathews, Morris and Moyer: Am. Pract. & Dig. Treat. 6:360 (Mar.) 1955.

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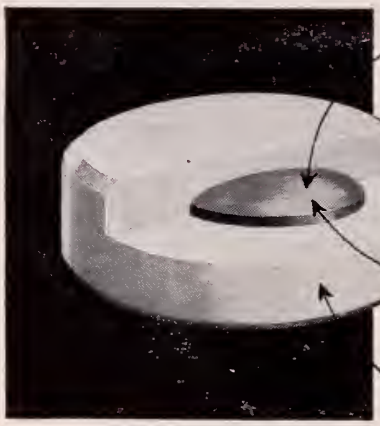

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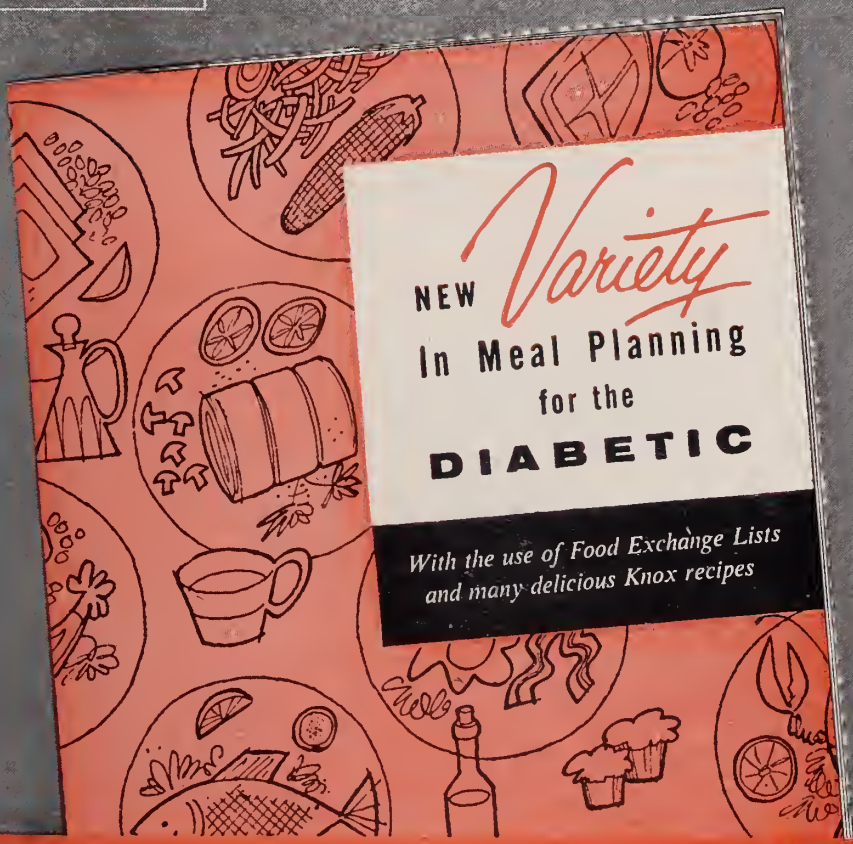

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Wine, however, the classic beverage of moderation, used as an aperitif, has been found to exert a profound stimulating effect on appetite and on the ability of both normal and anorexic patients to detect faint odors.[3] Goetzl and his co-workers have attributed this effect to such wine components as tannic acid, tartaric acid and acetic acid.[4, 5]

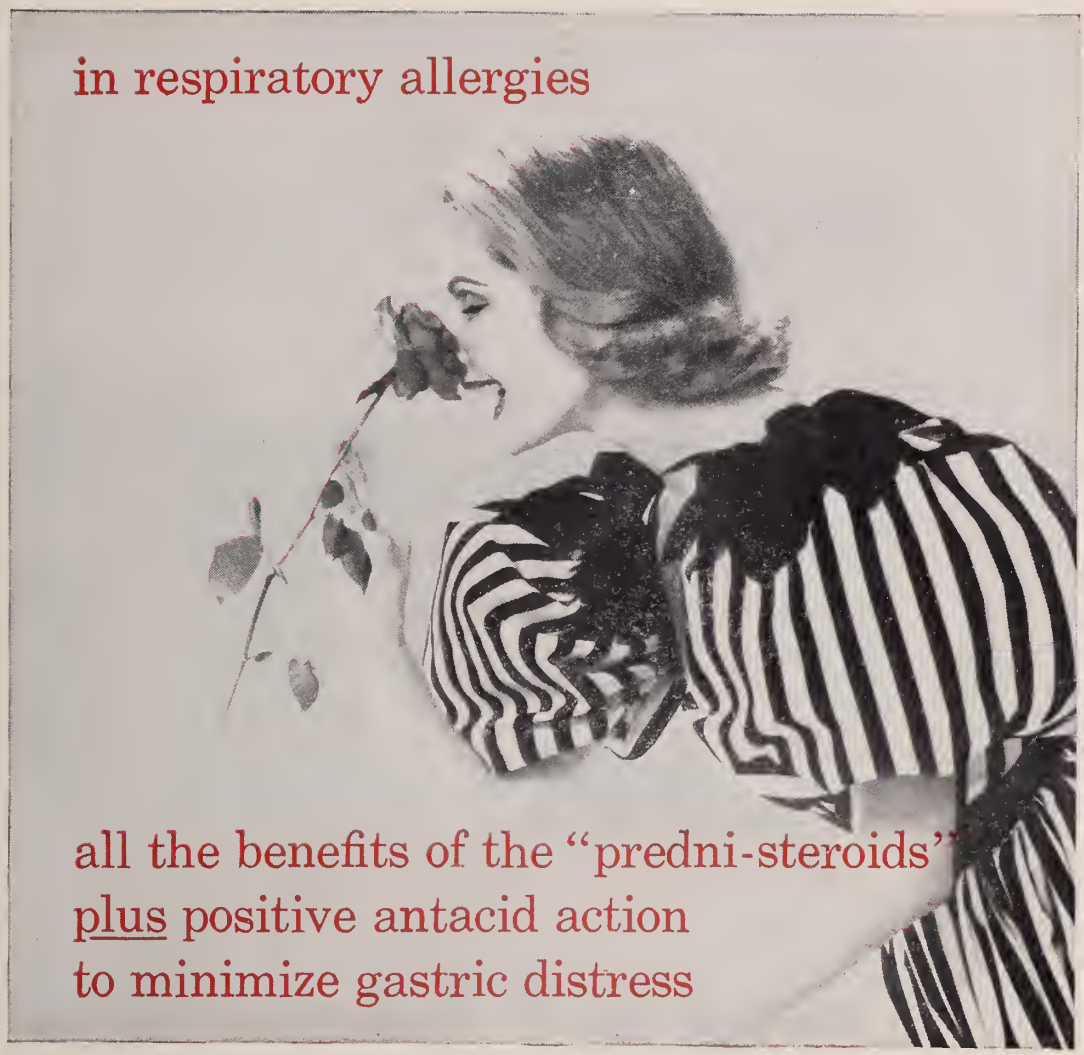
In actual clinical trials, Goetzl has reported the successful use of dry wines in increasing not merely the appetite, but also the food intake of patients suffering from anorexia. In one study on the appetite-stimulating action of wine, the average daily caloric intake in a substantial group of anorexic patients was increased from an average of 773 to 1228 calories.[6]

The above excerpts are taken from the brochure "Uses of Wine in Medical Practice" which describes the results of recent laboratory and clinical research on the medical attributes of wine. Herein are reported the latest findings on the value of wine as a stimulant to flagging appetite, as an aid to digestion, as a vasodilator, as a daytime and night-time sedative.

A copy of the brochure is available to you—at no expense—by writing to: Wine Advisory Board, 717 Market Street, San Francisco, California.

1. Margulies, N.R.; Irvin, D.L., and Goetzl, F.R.: Permanente Found. M. Bull. **8**:1 (Jan.) 1950.
2. Irvin, D.L.; Ahokas, A.J., and Goetzl, F.R.: Permanente Found. M. Bull. **8**:97 (Oct.) 1950.
3. Goetzl, F.R.: Permanente Found. M. Bull. **8**:72 (April) 1950.
4. Irvin, D.L., and Goetzl, F.R.: Permanente Found. M. Bull. **9**:119 (Oct.) 1951.
5. Irvin, D.L.; Durra, A., and Goetzl, F.R.: Am. J. Digest. Dis. **20**:17 (Jan.) 1953.
6. Goetzl, F.R.: A Note on the Possible Usefulness of Wine in the Management of Anorexia, unpublished.

in respiratory allergies



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prednisone or
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300 mg. aluminum
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Clinical evidence[1,2,3] indicates that to augment the therapeutic advantages of prednisone and prednisolone, antacids should be *routinely* co-administered to minimize gastric distress.

References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al.*, *J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al.*, *J.A.M.A.* 158:459 (June 11) 1955.

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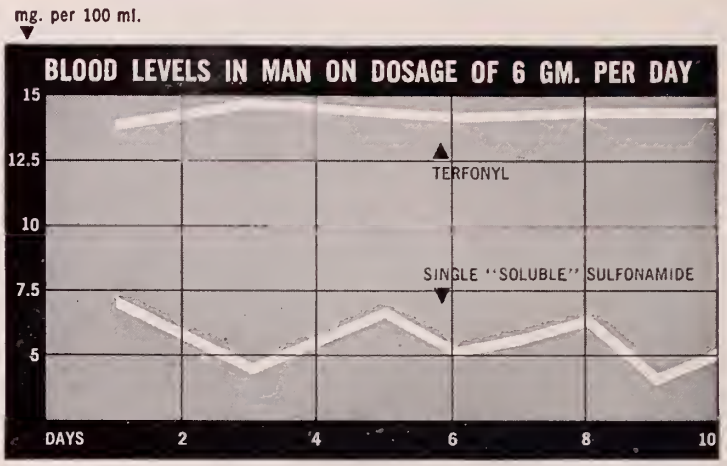

— After Lehr, D., Modern Med. 23:111 (Jan. 15) 1955.

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Paper Electrophoresis in Clinical Medicine

CHARLES CATANZARO, M.D.
TAMPA

It was with foresight and projected appreciation that the Nobel Prize was awarded to Tiselius in 1948 for the development of the electrophoretic apparatus which he presented to the scientific world about 11 years earlier. While those who followed and modified the apparatus into a more practical and improved instrument did not receive similar honors, mankind nonetheless owes them its gratitude. Among these are Lewis G. Longsworth of the Rockefeller Institute and Emmett L. Durrum of the United States, Svennson and Ingra Brattsten of Sweden, and Theodore Wieland and Fritz Turba of Germany.

Extremely rapid advances have been made in the use of the electrophoretic technic. The rapidity with which these advances have been made has not been generally appreciated.

Robert A. Alberty in the Journal of Chemical Education, volume 25, numbers 8 and 11, made this statement: "The number of laboratories in this country (U.S.) equipped to do electrophoresis has increased from 5 in 1940 to about 50 in 1948."

George W. Gray of the Rockefeller Institute, writing in the December 1951 issue of the Scientific American, stated: "Even though electrophoresis cannot be regarded as a primary prognostic or diagnostic device at the present time, its service as the biological chemists' most reliable analytical stratagem gives it a practical value to clinical medicine." He concluded: "It seems safe to predict that in the course of a few years electrophoresis will be as indispensable to medical practice as x-rays are today."

As late as July 1955, C. A. J. von Frijtag Drabbe and John G. Reinhold in Analytical Chemistry stated: "The simplicity of the technique and apparatus and the minute amounts of serum required make paper electrophoresis a procedure of great promise in clinical chemistry."

All of these reports project the effective clinical use of the procedure into the future. While it is true that its greatest fruits are yet to be realized, enough can be done at the present time to condense part of the optimism for the future into a practical present everyday laboratory function.

In the past year, in our laboratory my associate, Dr. James N. Patterson, and I have made effective use of our Spinco apparatus with most rewarding results. We have made some diagnoses almost exclusively on the basis of patterns obtained, confirmed others and ruled out still others, and we have thus learned to appreciate the technic's present practicabilities and future potential.

The substances most frequently analyzed in clinical pathology with the aid of this procedure are hemoglobin solutions and serums. Since the inception of the technic, several types of hemoglobin have been recognized on the basis of their varying mobilities in a controlled electrical field and appropriate ionic buffer. In our experience, we have made several diagnoses of sickle cell trait and one of sickle cell anemia, the latter in a Caucasian, which could not have been definitely made without this procedure.

The electrophoretic technic as used today as a tool in clinical diagnosis is concerned mostly with the qualitative and quantitative characterization of five protein fractions, namely, albumin, and alpha-1, alpha-2, beta and gamma globulins. Figure 1 presents a normal pattern and figure 2 the normal values.

The complete story even limited to these five protein fractions is far from being told, for these protein fractions in reality represent complexes consisting of portions which are bound to lipids,

Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami Beach, May 14, 1956.

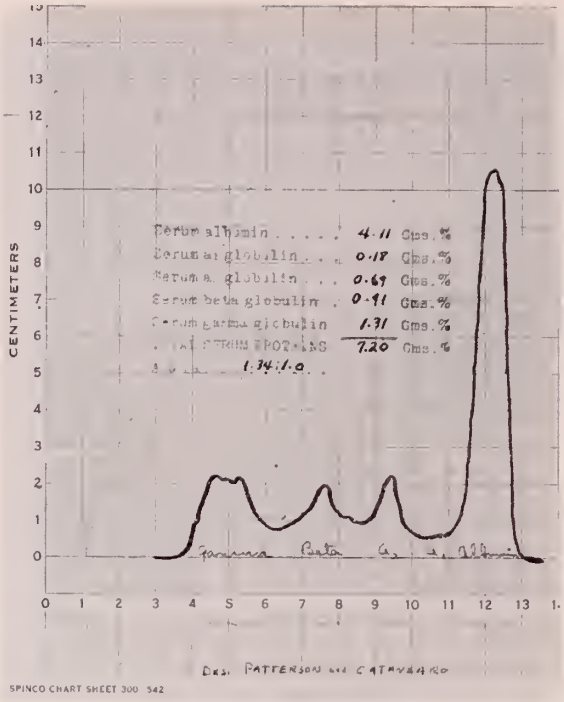

Fig. 1. — A normal serum pattern.

carbohydrates, and minerals such as iron. Some of these complexes are recognized as being intimately related to some definite disease processes when present in excess or when deficient. The lipoproteins, for example, are bound to the beta fraction and to a lesser extent to the alpha-2 fraction. The serum mucoproteins are bound to the alpha-1 fraction. The serum iron is largely bound to the beta fraction. What the functional interrelationships in a concrete way actually are constitutes a veritable Alice-in-Wonderland in medicine and medical research.

In many instances of alterations of the serum protein fractions, the total proteins are found to be normal or even increased. Despite the normal or increased total protein, the albumin fraction is often decreased, there being a concomitant rise in one or more of the globulin

NORMAL SERUM PROTEIN FRACTIONS -- PAPER ELECTROPHORESIS

	GM/100 ML.	%
ALBUMIN	3.5 - 5.0	60 - 62
ALPHA-1 GLOBULIN	0.20 - 0.40	3 - 5
ALPHA-2 GLOBULIN	0.40 - 0.70	6 - 9
BETA GLOBULIN	0.60 - 1.0	10 - 12
GAMMA GLOBULIN	0.80 - 1.45	15 - 18

NORMAL TOTAL SERUM PROTEINS -- 6 - 8 GM/100 ML

NORMAL TOTAL SERUM GLOBULINS -- 2.0 - 3.45 GM/100 ML

Fig. 2. — Table of normal values.

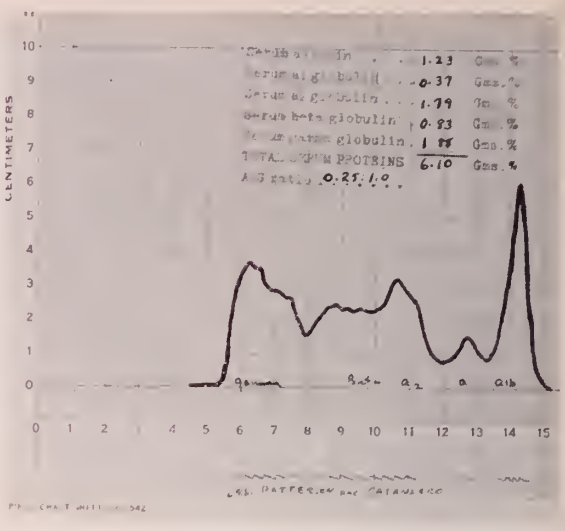

Fig. 3. — Serum pattern showing a low albumin due primarily to malnutrition.

fractions. When these changes occur independently of disease of the liver, in which the major defect is in albumin synthesis within the liver itself, there apparently is a selective and preferential utilization of absorbed amino acids and of the amino acids derived from general protein catabolism. Thus there appears to be a regulatory mechanism which may cause an increased avidity on the part of some cells which have become deranged in their normal metabolic functions and interrelationships with other organs or organ systems. The elucidation of the mechanism or mechanisms involved is still before us.

Altered Protein Patterns

Along a more practical vein let us review some concrete examples of altered protein patterns in specific disease processes.

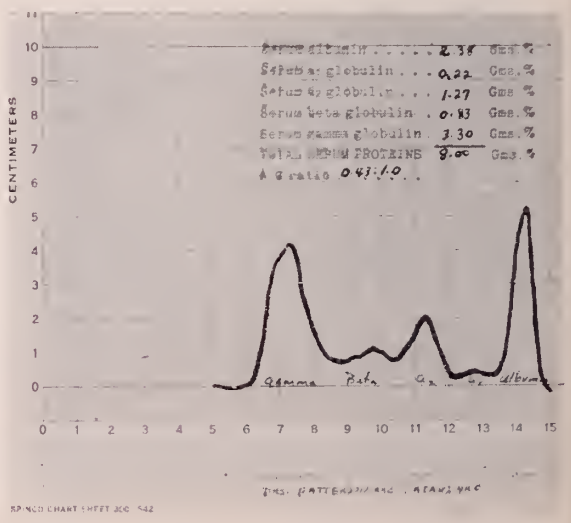

Fig. 4. — Serum pattern showing an immune reaction with a low albumin.

Figure 3 presents a serum electrophoretic pattern obtained on the serum of a 61 year old man who underwent a subtotal gastrectomy on July 18, 1955 for an obstructing duodenal ulcer. For 12 years previously he had been unable to eat solids and had subsisted practically entirely on liquids. Postoperatively, a duodenal fistula developed, which closed after nine weeks. In October 1955, a large abdominal abscess was drained, which extended from the tail of the pancreas almost to the pelvis. There was difficulty in wound healing, but the total proteins were normal. The electrophoretic separation of the serum protein constituents showed a low albumin value, accounting, at least in part, for the poor wound healing and stormy postoperative course. He was given 1 liter of plasma daily for many days, after which he showed temporary improvement. He died five weeks after the last operation.

The pattern shown in figure 4 was obtained on the serum of a 16 month old boy who fell out of a highchair on Nov. 4, 1955. Soon thereafter a swelling was noted beneath the upper end of the left sternocleidomastoid muscle. The child had fever and leukocytosis with a predominance of neutrophils. Physical examination, except for the mass, gave negative results. About two and a half weeks later, the mass had increased in size from 4 cm. in diameter to 8 cm. in diameter. On the assumption that the mass may have been of an inflammatory nature, penicillin was administered; after several days the mass disappeared completely, and the child became symptom-free. The pattern shown here was obtained just before penicillin treatment was instituted. The total proteins were high normal, but the albumin fraction was markedly decreased. Accounting largely for the normal total protein was the greatly elevated gamma globulin and moderately elevated alpha-2 globulin. To account for the low albumin are several factors. One is the increased general body catabolism resulting from the inflammatory process with fever. A second is possibly the preferential utilization of available amino acids needed in the synthesis of the immune bodies in the form of gamma globulin. A third factor is probably the decreased intake of adequate nourishment in the form of protein to keep pace with the destruction. The alpha-2 globulin tends to vary inversely with albumin and probably in this case has no other pathologic significance. At times, however, in malignant processes a combination of a low albumin and an

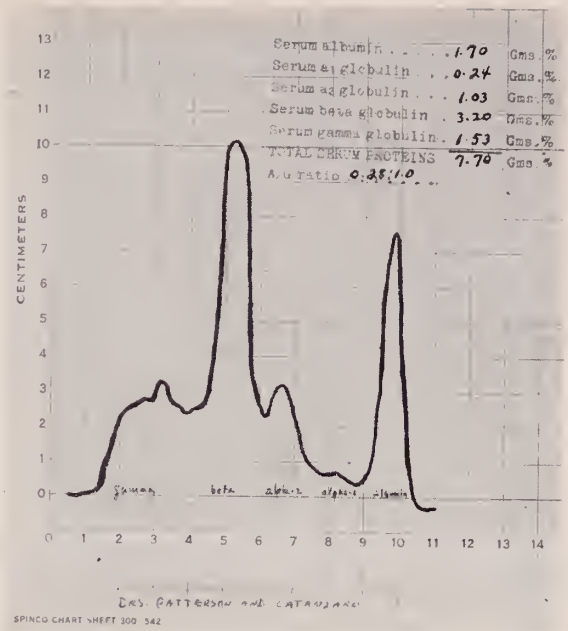

Fig. 5. — Serum pattern showing the effect of hemoglobin in the beta fraction. The albumin is markedly decreased.

increased alpha-2 globulin is seen without any other discernible protein abnormalities.

The pattern of serum shown in figure 5 was sent to us from a 73 year old woman who in September 1955 had signs, symptoms and a PBI value (8.75 mcg/100 ml) indicative of hyperthyroidism. She improved with appropriate therapy. In November 1955 pneumonia developed on the right side without pleural effusion; it did not respond to antibiotics, but apparently did respond to ACTH. She was well until January

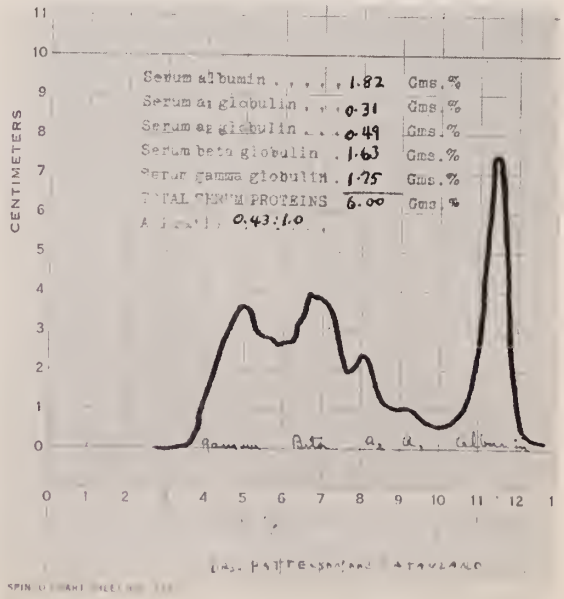

Fig. 6. — Serum pattern from the same patient as in figure 5, but without hemolysis. The beta fraction no longer shows the hemoglobin component.

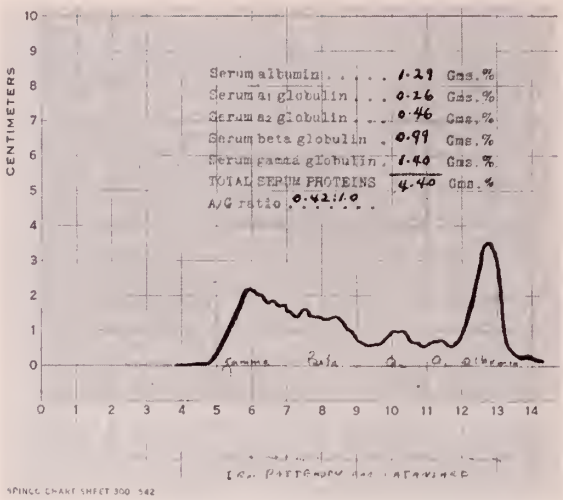

Fig. 7. — Pattern of pleural fluid from the same patient as in figures 5 and 6.

1956, when she became dyspneic, and the right side of the chest filled with fluid. It was at this time that we received serum for a pattern. This is a bizarre picture and quite misleading, I might say, were it not for the fact that upon receipt the serum was noted to be very red, indicating excessive hemolysis of red cells in transport. We can say unequivocally that the albumin fraction is decreased, and the alpha-2 and gamma globulins are increased. The large amount of hemoglobin protein migrated with the mobility of a beta globulin. An unhemolyzed specimen was requested, and the study was repeated.

In figure 6 the picture is seen to have changed considerably. The albumin is markedly decreased

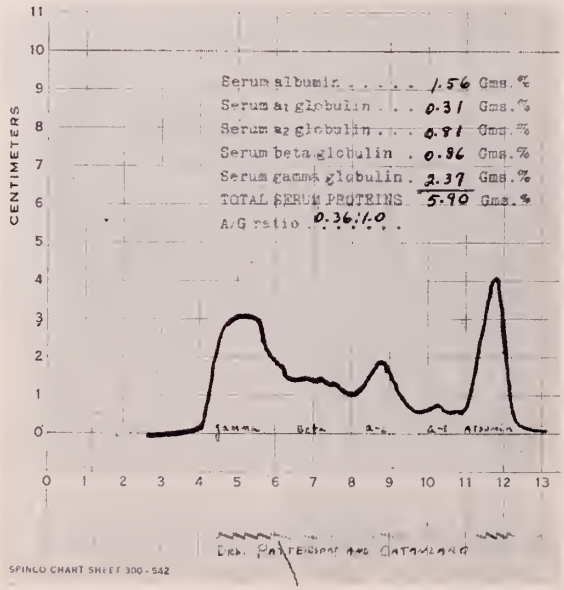

Fig. 8. — Serum pattern showing a markedly decreased albumin and an elevated gamma globulin in a case of cirrhosis of the liver with ascites.

while the beta and gamma globulins are increased. The hemoglobin component is absent, as was expected from the gross absence of hemoglobin in the serum. The pleural fluid obtained from this patient was also analyzed.

The pleural fluid pattern presented in figure 7 indicates that this patient was losing considerable amounts of protein including not only albumin but some of all of the globulin fractions as well. On this basis we can at least partially account for the low serum albumin, but it also becomes obvious that the globulin fractions in the serum would ordinarily have been even higher than the previous figure showed.

This patient required repeated thoracentesis at intervals of every two weeks. Microscopic examination of the pleural sediment for tumor cells showed cells which were compatible with, but not definitely diagnostic of, malignant cells. The final story in this case cannot be told at this time because the patient went North for an indefinite period and has not been heard of since.

Figure 8 shows a serum pattern from a 78 year old man with a gradual accumulation of ascitic fluid over several months associated with anorexia, loss in weight, dyspnea and edema of the ankles. The ascitic fluid showed no cells suggestive of a malignant process.

The markedly decreased albumin and increased gamma globulin are often seen in association with a severe lesion of the liver, most commonly cirrhosis.

The patient has improved on treatment for a cirrhotic process, but periodic paracentesis is still necessary.

The tracing shown in figure 9 is of a serum from a 55 year old woman whose disease had previously been diagnosed as hemochromatosis on the basis of skin and liver biopsies with appropriate iron stains.

The picture is that seen in severe cirrhosis from any cause, namely, a decreased albumin and a markedly increased gamma globulin with a wide contour.

Figure 10 shows the tracing of serum from a 55 year old school teacher who in the latter months of 1955 and early months of 1956 complained of nausea, anorexia and fatigue with loss in weight. The urine became dark and the stools light in color. The sclerae were jaundiced, and the liver was tender and enlarged to the level of the umbilicus. The thymol turbidity on March 15, 1956 was 26.5 Shank-Hoagland units, and the

cephalin-cholesterol flocculation was 4 plus. The van den Bergh test showed the changes of an obstructive type of hyperbilirubinemia. The serum tracing shows the classic changes associated with a severe lesion of the liver, namely, a decreased albumin and an elevated gamma globulin with the contour of the gamma peak being wide. This patient has improved clinically on corticosteroids and is about due to have the serum pattern repeated.

The pattern of serum from a young child with repeated infections is shown in figure 11. The tracing is exemplary of a hypogammaglobulinemia, the gamma globulin being only one half of the accepted lower limit of normal.

The tracing in figure 12 is of serum from a 43 year old truck driver who first began to complain of lumbosacral pain in September 1955. He was treated for arthritis without response. Several years previously he had had a subtotal gastrectomy. A bone marrow aspiration showed extensive replacement of the normal elements by a malignant process compatible with that of stomach origin. Roentgenograms of the lumbosacral area showed osteolytic changes compatible with tumor. Bleeding into the gastrointestinal tract began, and, despite blood transfusions, he died. Permission for autopsy was not granted.

The tracing shows a markedly lowered albumin fraction attributable to the malignant process and possibly partially to an inadequate dietary animal protein intake.

Figure 13 shows a tracing from the serum in a patient with a most fascinating history. He was a 37 year old white man who intermittently for 20 years had had episodes of jaundice and numerous transfusions. Also, 20 years previously he had been told his liver was enlarged, and 10 years previously he had been told his spleen was enlarged. For three months prior to the last hospital admission he became increasingly jaundiced and anemic. Upon admission to the hospital he was in extremis. He received several blood transfusions but died about 24 hours after admission.

This tracing shows findings typical of a cirrhotic lesion, namely, a markedly decreased albumin and an increased gamma globulin.

Figure 14 shows a hemoglobin migration pattern obtained on the father of this patient showing both normal (A) hemoglobin and sickle cell (S) hemoglobin. Thus the presence of the A hemoglobin definitely establishes the diagnosis of

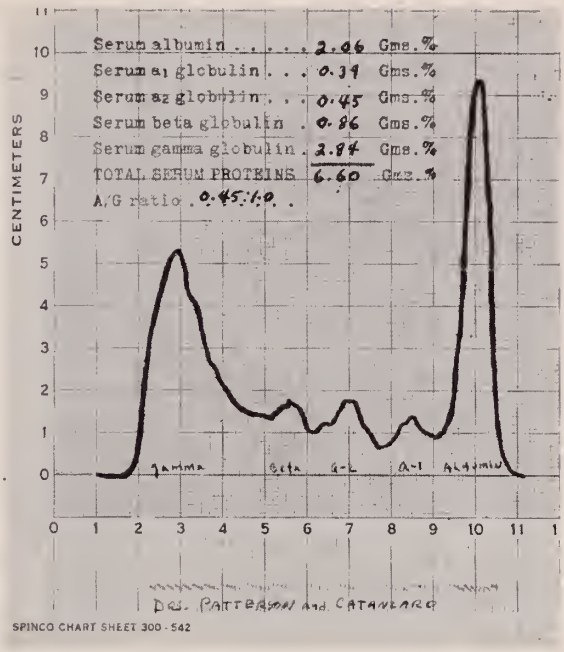

Fig. 9. — Serum pattern showing a decreased albumin and a markedly increased gamma globulin secondary to liver involvement due to hemochromatosis.

sickle cell trait (SCT) and rules out sickle cell anemia (SCA) in the father.

We attempted to solicit the mother's cooperation in letting us get a pattern on her hemoglobin, but she refused to grant this permission.

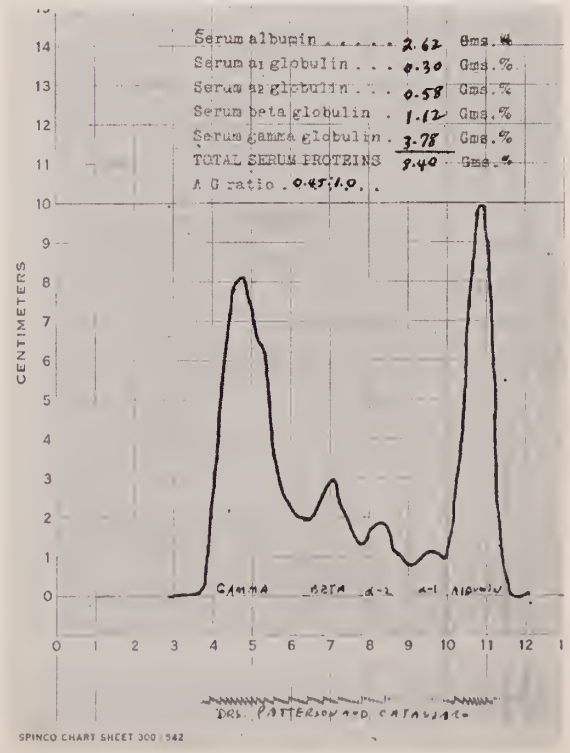

Fig. 10. — Serum pattern in a case of infectious hepatitis. The albumin is decreased; the gamma globulin is markedly increased.

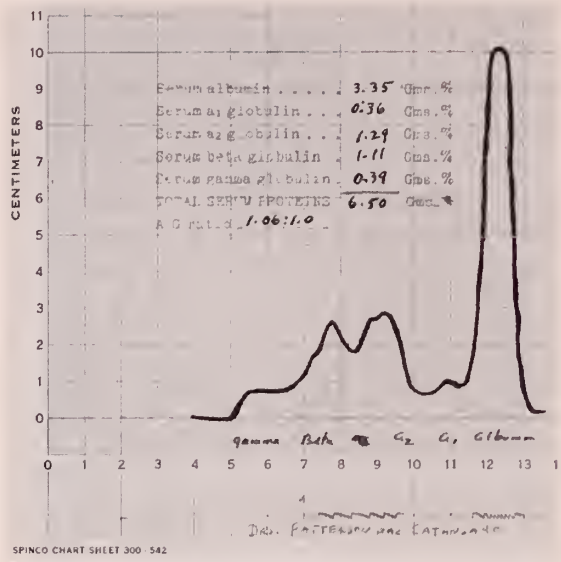

Fig. 11. — Serum pattern from a child having repeated upper respiratory infections. The gamma globulin is definitely decreased.

The hemoglobin migration pattern shown in figure 15 was obtained on the patient's blood *after* transfusion. It also shows normal adult (A) hemoglobin and sickle cell (S) hemoglobin suggesting at least the sickle cell trait.

A hemoglobin migration pattern, however, obtained on the blood of this patient (received from the blood bank) *before* he had been given several transfusions showed only S hemoglobin (fig. 16). Thus the fact was established that this patient had

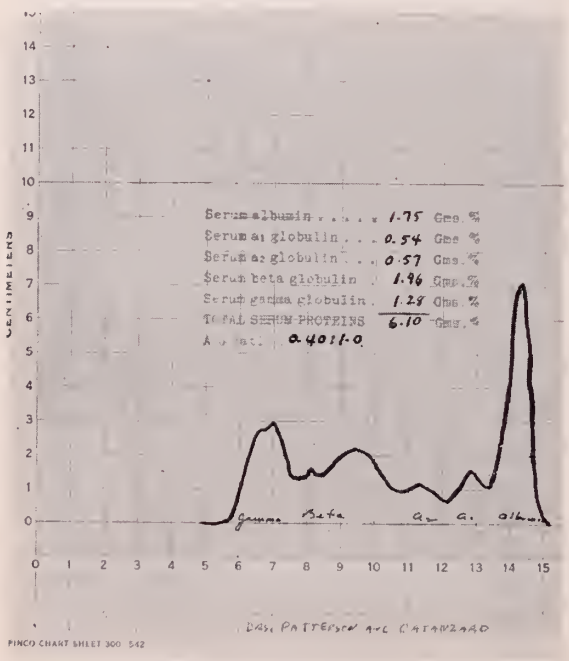

Fig. 12. — Serum pattern in a case of carcinomatosis. The albumin is markedly decreased.

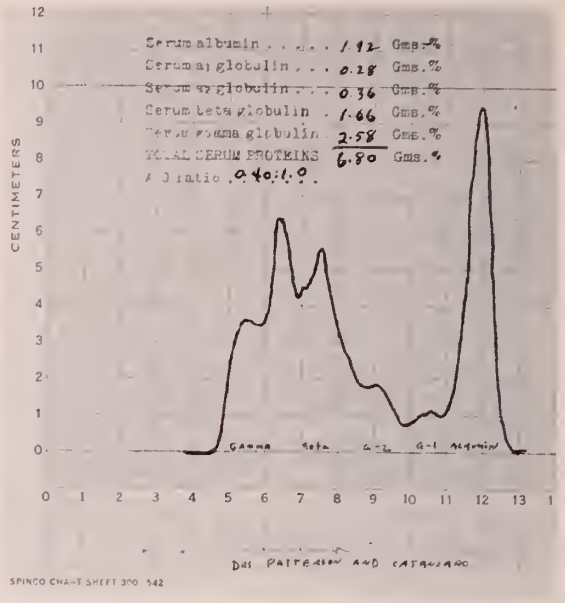

Fig. 13. — Serum pattern in a case of long-standing sickle cell anemia with liver involvement. The albumin is decreased, and the beta and gamma globulins are markedly increased.

sickle cell anemia and not a combination of sickle cell trait and chronic spherocytic anemia as had previously been thought. It also conclusively ruled out microdrepanocytic disease, which he had also been suspected of having at one time largely because of his Mediterranean ancestry.

The possible presence of F hemoglobin, which has practically the same mobility as that of A hemoglobin, was ruled out in these cases by alkali denaturation tests. Appropriate tests for sickling were also carried out, but lack of time does not permit further discussion of this work.

Ante mortem it was concluded that this patient was the victim of sickle cell anemia with repeated crises for all these years and with a cirrhotic liver process which is frequently seen in cases of sickle cell anemia of relatively long standing. We know that the patient received an S gene from his father and we are quite certain the mother, too, must have transmitted an S gene in order for the patient to have practically all S hemoglobin.

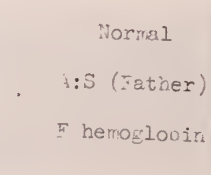

Fig. 14. — A hemoglobin pattern from the father of the same patient whose serum pattern is illustrated in figure 13. This pattern shows A and S hemoglobins as seen in sickle cell trait.

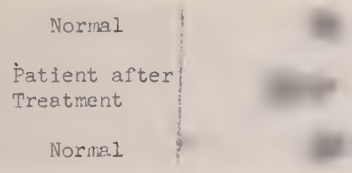

Fig. 15. — A hemoglobin pattern from the same patient whose serum pattern is illustrated in figure 13. The patient had been treated with several transfusions. The pattern shows both A and S hemoglobins.

At autopsy a completely fibrosed spleen weighing 8 Gm. was found, and the cirrhosis of the liver was confirmed. He died of a massive gastrointestinal hemorrhage.

Presented in figure 17 is a serum tracing from a 14 year old boy who had the urinary findings of nephrosis, a serum cholesterol of 620 mg/100 ml, and total serum lipids of 2,780 mg/100 ml (normal=340-900 mg/100 ml).

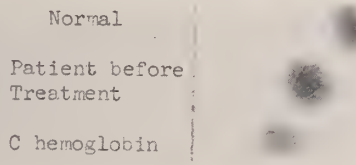

Fig. 16. — A hemoglobin pattern from the same patient as in figure 15, but done on the patient's blood prior to his having been treated with several transfusions. The pattern shows only S hemoglobin as seen in sickle cell anemia.

To be noted here are the extremely low albumin value largely accounting for the edema seen in cases of this type, the elevated alpha-2 globulin which tends to vary inversely with the albumin fraction, the decreased gamma globulin which is largely responsible for the tendency to

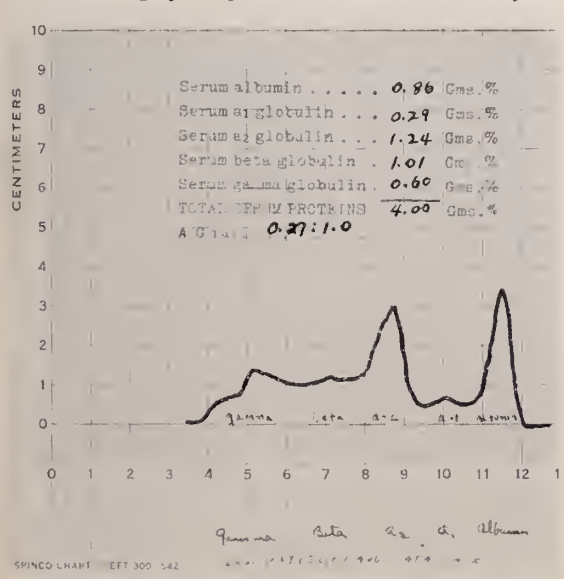

Fig. 17. — A serum pattern from a patient with nephrosis. The albumin and gamma globulins are decreased.

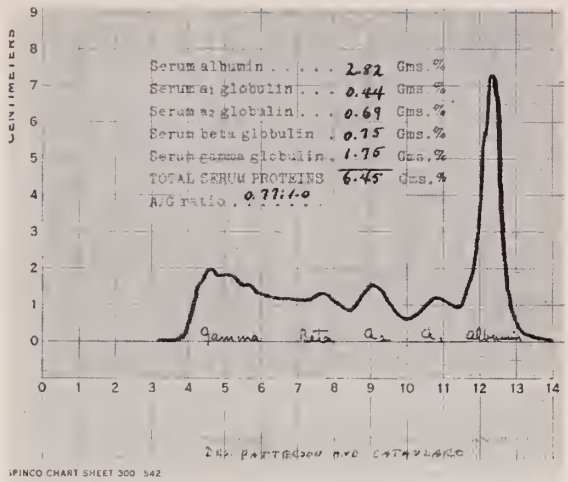

Fig. 18. — A serum pattern from a patient with disseminated lupus erythematosus before treatment. The albumin is decreased, and the gamma globulin is increased.

infection in these cases, and finally the low beta globulin which is generally increased with hyperlipemias. Undoubtedly, all the protein fractions except possibly alpha-2 were being lost in the urine in large amounts.

The serum tracing shown in figure 18 was obtained from a young girl with disseminated lupus erythematosus. She had the classical butterfly rash over the bridge of the nose and extending onto the cheeks, and at the time of this tracing had rather numerous L.E. cells in appropriate preparations.

The low albumin and increased gamma globulins along with other clinical findings are characteristic of this entity. She was treated

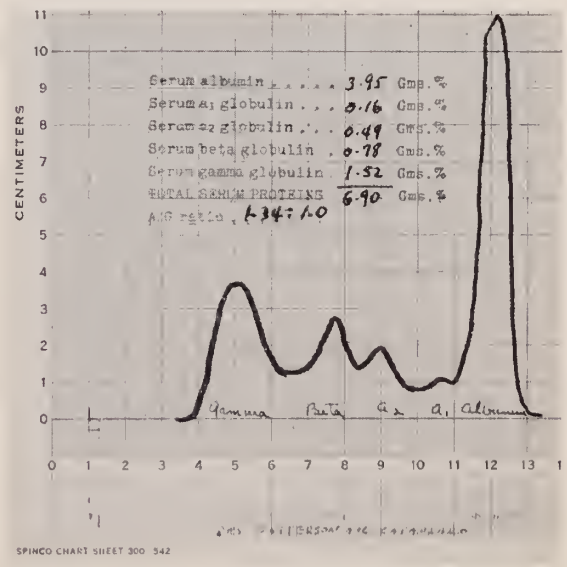

Fig. 19. — A serum pattern from the same patient as in figure 18 two months after the institution of treatment with corticosteroids. The albumin has reverted to normal, and the gamma globulin has decreased.

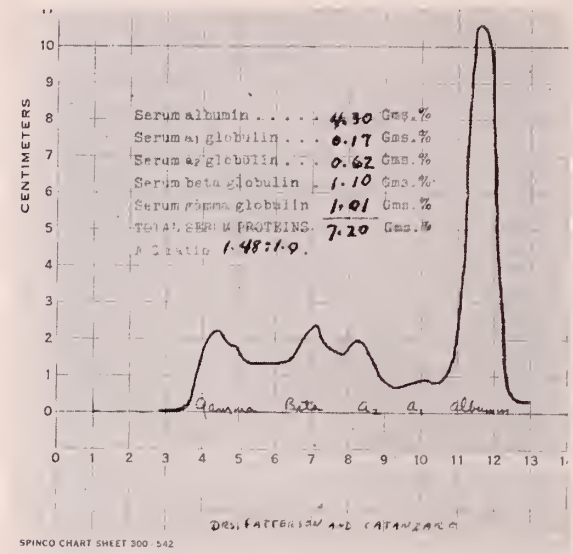

Fig. 20. — A serum pattern from the same patient as in figures 18 and 19 and done five months after the institution of treatment with corticosteroids. Both the albumin and gamma globulins are normal.

with corticosteroids, and the serum pattern was repeated two months later.

Definite objective evidence of improvement is shown in figure 19 by the increase in the albumin and the decrease in the gamma globulin. Smears for L.E. cells showed a definite decrease in their incidence.

A third tracing, obtained five months after the institution of therapy and three months after the previous tracing, is shown in figure 20. The albumin is well within normal limits, and the gamma globulin has reverted to normal.

Multiple myeloma is a disease with serum protein changes which, when studied by this technic, are nearly always practically pathognomonic of the disease. In several cases we have ventured to make the diagnosis practically on the serum tracing alone, and the diagnosis was later verified by marrow studies and roentgen studies. Other cases with suggestive roentgen studies and high total proteins, including elevated total globulins, we have verified as being cases of multiple myeloma.

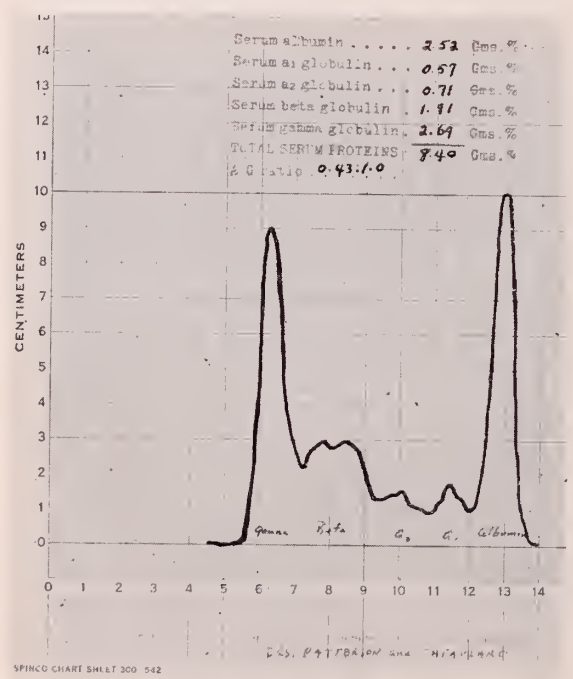

Fig. 21. — A serum pattern from a case of multiple myeloma. The tall gamma globulin peak and the narrow contour are characteristically seen in most cases of this disease.

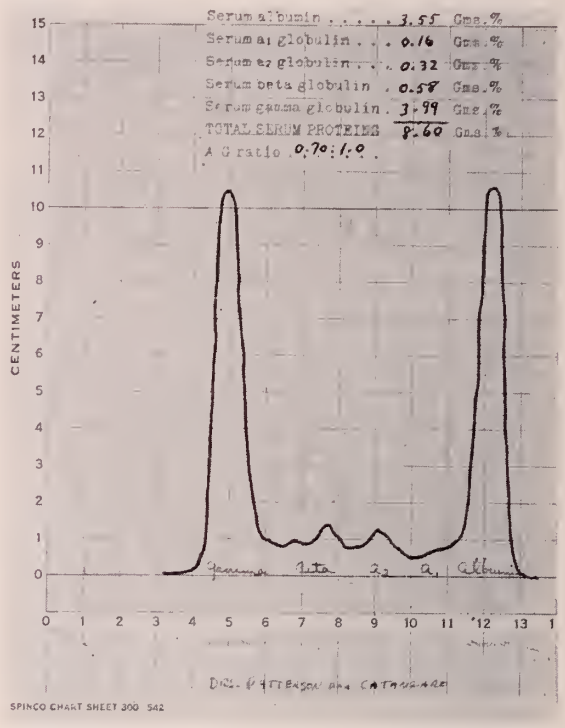

Fig. 22. — A serum pattern from another case of multiple myeloma. The gamma globulin peak is similar to that seen in figure 21.

Figure 21 shows a serum pattern obtained from a man over 60 years of age who complained of chest pain on deep breathing for two weeks prior to his having seen his physician. Physical findings and routine laboratory studies prior to this tracing showed no abnormalities including the absence of anemia. Roentgen studies of the bones of the chest gave negative evidence. On the basis of this tracing we made a provisional diagnosis of multiple myeloma, which was later verified by bone marrow studies. Characteristic in this tracing is the increased gamma globulin with a tall narrow contour.

The tracing shown in figure 22 is of serum from a 50 year old woman who physically appears well and who has no serious complaints. She had

been studied at the Ochsner Clinic in 1954 for excessive vaginal bleeding during her menstrual periods. There she was found to have a submucous leiomyoma. A bone marrow aspiration study showed numerous plasma cells, leading to a diagnosis of multiple myeloma. The case and slides were reviewed by a well known Boston hematologist, who concurred in the diagnosis of multiple myeloma. All roentgen studies to date have given negative results. The patient has no pain in the bones. The tracing shows what is considered to be practically diagnostic of multiple myeloma.

Thus far examples of the so-called gamma globulin multiple myeloma have been presented. At times the predominating and characteristic peak is in the beta globulin fraction, and this is called the beta globulin multiple myeloma. Generally speaking, multiple myeloma giving a beta peak is a more fulminating process with a less favorable prognosis. The tracing shown in figure 23 is from the serum of an 85 year old woman who complained of pain in the bones most severe in the lower portion of the back over the sacrum. Roentgen study of the entire skeleton except for the skull revealed only arthritic changes. The skull showed the punched-out areas frequently seen in multiple myeloma. A bone marrow study proved this case to be, in fact, one of multiple myeloma.

On the basis of what I have said, there will be some in the audience who have probably already made at least a provisional diagnosis of multiple myeloma from the tracing shown in figure 24, and with some justification. As a matter of fact, this diagnosis in this case had already been made elsewhere, and not only was the diagnosis of multiple myeloma made but also the diagnosis of a superimposed chronic lymphatic leukemia. We were asked to study this patient, and the tracing obtained as well as the total proteins was consistent with a diagnosis of multiple myeloma. Bone marrow studies, however, failed to show an abnormal number of plasma cells; and, thus, this diagnosis became unlikely. The bone marrow aspiration smears showed a preponderance of lymphocytes; but these were atypical lymphocytes, some consisting almost entirely of nucleus.

While performing the routine studies such as sedimentation rate, our chief technologist made some astute observations which were not consistent with those seen in a lymphocytic leukemia. Left throughout the plasma column after most of

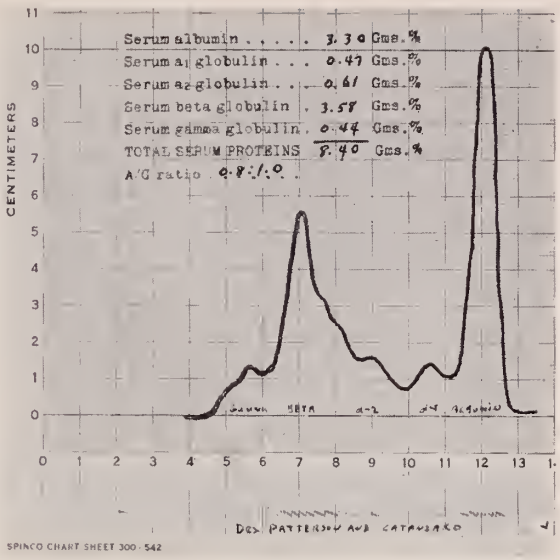

Fig. 23. — A serum pattern from a third case of multiple myeloma. In this case, the sharp peak is seen in the beta fraction.

the cells had sedimented were small clumps of red cells which appeared to show little tendency to settle. Also, on cooling the plasma or serum, coagulations were noted, which disappeared upon warming. These were cryoglobulins. Appropriate studies including the distilled water–electrolyte solution euglobulin test were made, the results of

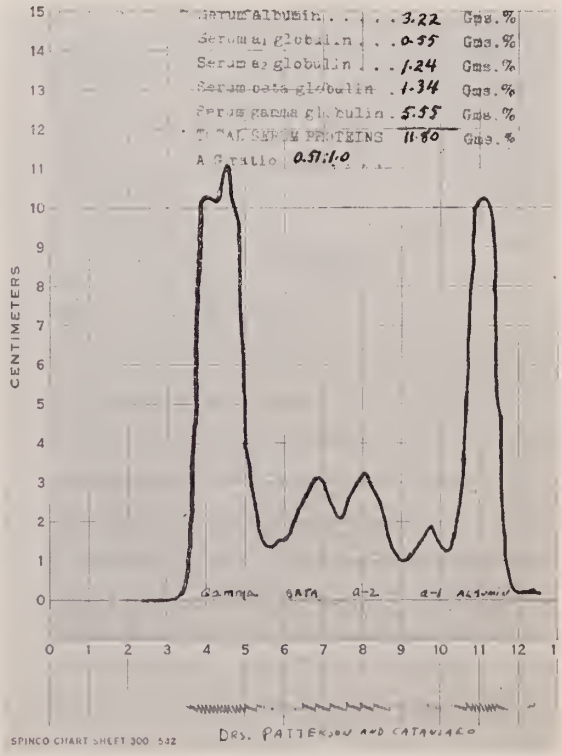

Fig. 24. — A serum pattern from a case of Waldenström's syndrome—macroglobulinemia. The gamma globulin peak is strongly reminiscent of that seen in multiple myeloma.

which showed that we were also dealing with a macroglobulin. We then concluded that this patient had neither multiple myeloma nor chronic lymphatic leukemia but rather the uncommon entity known as Waldenström's syndrome — macroglobulinemia. The macroglobulin was precipitated out in distilled water, and an electrophoretic analysis showed that it had a mobility identical to that of gamma globulin and constituted approximately 62 per cent of the total moiety migrating as gamma globulin on the original tracing.

Conclusion

Thus, electrophoresis, a Nobel prize-winning discovery in 1937, has now become an important clinical diagnostic tool. The patterns shown are only a few of those obtained, but they, I believe, are enough to show the clinical implications of the technic today.

It appears that the Art of Medicine, while it will and should always be an important aspect of medical practice, must inevitably give way to the potent and effective Science of Medicine. The cry, both on the part of physicians and on the part of an educated public, is for a more and more precise definitive answer.

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Discussion

DR. NELSON A. MURRAY, Jacksonville: During the past decade, the most important contributions to clinical chemistry were the determination of protein-bound iodine, the versenate titration of calcium, and the flame photometric determination of sodium and potassium. The most important contributions to this same science during the present decade will probably be the application of paper electrophoresis and paper chromatography to clinical medicine.

Paper electrophoresis is emerging rapidly from the realm of pure science, and even now we are able to separate the alpha, beta, and gamma globulins easily, as well as several hemoglobin factors. This new tool will give us additional insight into the body chemistry and, we hope, make better physicians of us all.

Problems of the Skin Associated with Aging

MORRIS WAISMAN, M.D.
TAMPA

The mystery of the mechanism of aging is almost totally unsolved. Under the influence of hereditary factors, various organs age at differing rates in the same person. Premature aging of the skin is a characteristic of progeria, in common with senile changes of other organs; and it occurs also in such other rare conditions as xeroderma pigmentosum and Werner's and Rothmund's syndromes. That the aging process of the skin can be accelerated by sun and harsh weather is well known, for the indelible imprint of sunlight on the white skin is only too conspicuous in Florida. Other conditions which cause the skin to acquire signs of age are less obvious. Enzymatic reactions in the connective tissue and epithelial structures are undoubtedly retarded or even qualitatively modified with age, and these may have their genesis in changes of controlling endocrine secretions; or, narrowing of cutaneous arterioles, with consequent impairment of tissue nutrition and metabolism, may initiate alterations which eventuate in demonstrable marks of aging.

Whatever the causes, the effects are familiar enough: a yellowish, dry, wrinkled, inelastic skin, usually parchment-thin (but in places sometimes thickened and opaque, as if coagulated, the surface pebbled or corrugated or cross-hatched), with decreased activity of sweat and sebaceous glands and hair follicles. As the hairs of the scalp become fewer, and also those of the axillas and pubis, the hairs of the ears and nostrils turn bristly and the eyebrows bushy. The longitudinal ridges of the fingernails grow coarsened. Contrasting with the declining vigor of the male beard is the ascendant growth of whiskers in elderly women, thanks to androgens elaborated by the adrenal cortex. Occasionally the greasy, florid face and thickened nose of a bibulous old man contrasts with the prototypal pinched features of old age.

"Unnatural" cutaneous changes may under special circumstances be induced in old age, such as darkening of gray hair of men treated with estrogens for carcinoma of the prostate, or "adolescent" acne in women receiving androgens, or rounding of a senile sunken face as the result of administration of cortisone or corticotropin. Veins of older people become more conspicuous due to thinning of overlying skin and localized dilatations of the lumen. In some mucosal sites, such as on the lips or in the mouth, the presence of dark blue markings of a vein may lead to false

Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami Beach May 14, 1956.

suspicion of melanoma. After minor trauma or following exposure to the sun, multiple transient, purplish-red petechiae may erupt on the backs of the hands and forearms (senile, or solar, purpura). The mouth becomes drier as the salivary glands gradually atrophy. Senile alopecia is almost universal in males, contributing to the aspect of elderly wisdom. Senile thinning of the hair of the scalp is also frequent in women, but seldom is it as extensive as in men, nor is it so highly esteemed an intellectual asset.

Cutaneous Stigmata of Aging

Many pigmentary and tumor-like marks bespangle the aging skin. So do they younger skins also, but their variety and number are greater, as a rule, the older the patient. In early life the pigmented nevus is the common and characteristic lesion. As the years pass, the number of pigmented nevi increases, and new and different spots appear which have been aptly termed "senile barnacles" by Sams.[1] They include pigmented macules, keratotic nodules, fibrous tags, vascular excrescences and neoplastic tumors. It is important that the physician familiarize himself with their features, so that benign lesions may be differentiated from malignant ones, or from those potentially malignant.

Senile lentigines, the "freckles" of older people, are dark, coarse splotches of brownish pigmentation appearing over exposed areas of the skin, particularly the hands and forearms and the face and neck (fig. 1a). In vain are estrogen creams and other "miracle" cosmetics hopefully rubbed on by the expensive jarful; the lentigines persist. The condition is generally harmless, but at times a senile keratosis develops on a senile lentigo. Rarely, malignant change may result in evolution of a melanoma (lentigo maligna).

Tiny flat or globular, red or purplish angiomatous nodules appear in most adults, chiefly over the trunk, and equally in both sexes. Known as De Morgan ("ruby") spots, they are not indicative of hyperestrinemia as are cutaneous vascular "spiders" associated with liver disease and pregnancy, nor is there demonstrable connection with cancer. They need not be removed.

Senile keratoses[2,3] arise primarily as products of a weather-damaged skin, the changes accumulating from exposure to sun and wind rather than merely from passing of the years. Probably the terms "solar keratoses," or "weather keratoses," would be more precise. Owing their inception to weathering of the skin and particularly to chronic sunburning, they appear predominantly over the exposed parts—the face and neck, the bald scalp, the backs of the hands and forearms—and with greater frequency in light-skinned persons.

Senile keratoses are round or irregular and slightly elevated, the scaling surface colored a shade of brown or red. The dry, rough and adherent scale is sometimes so thin as to be hardly perceptible, sometimes so thick as to form a cutaneous "horn." Curettage demonstrates the scale to be invaginated and adherent, so that by this procedure often the lesion is gouged out entire, leaving a moist and reddened ulcer. Inflammation, if present, invites a strong presumption of the development of malignant change. Indeed, many senile keratoses are histologically malignant (squamous cell carcinoma in situ) despite an innocent appearance clinically. Although the likelihood of cancerous change looms relatively high, it is probably less than the 10 per cent to 20 per cent given in the textbooks.

Seborrheic keratoses, or seborrheic verrucae, crop up at any age, but mostly during middle life and beyond. Perhaps of the nature of delayed nevi, they are usually present on the face, neck and trunk; however, any area of the body, including the scalp, may be involved. The keratoses form round or ovoid growths, flattened or convex, covered by a thick velvety or waxy yellow, gray, brown or black scale which shows a granular or warty or papillary surface reminiscent of the texture of cauliflower (fig. 1b.) They appear to be stuck on the skin, so that removal by curettage leaves almost no indentation. Over moist intertriginous areas, as under the breasts and in the groins, the lesions often enjoy a luxuriant growth, swelling to mushroom-shaped masses. When dark-colored and relatively smooth, they may be mistaken for pigmented nevi and even for melanomas. Actually, they are the most benign of cutaneous neoplasms; but probably no lesion has fomented more frenzied apprehension among a public made fearfully cancer-conscious by unremitting cancer detection campaigns.

"Hard nevi"[1] are flat, rounded or polygonal papules which resemble flat warts (fig. 1c), emerging symmetrically on the backs of the hands and feet during the middle or later decades of life. The finely granular surface may assume the color of normal skin or a shade of gray or brown. Scattered lesions are encountered on the arms, trunk and other areas.

Small flattened or umbilicated translucent yellow papules, occurring chiefly on the forehead and cheeks, are known as senile sebaceous adenomas (fig. 1d). Representing hypertrophic rather than adenomatous sebaceous glands, they are important only because they may be mistakenly diagnosed as xanthomas or basal cell carcinomas.

Tiny papules and pedunculated dark excrescences, called cutaneous tags, arise over the neck and axillas of elderly people. Similar lesions appear on the skin of some women during pregnancy, disappearing in most instances after parturition. Microscopically, the larger of these tags show the structure of simple papillomas, but smaller ones are usually found to be seborrheic keratoses.

I would like to regard certain of the "barnacles" of senescence—notably senile angiomas, seborrheic keratoses, hard nevi and cutaneous tags—as nevoid growths, possibly induced by the physiologic overactivity of the anterior lobe of the pituitary gland and the adrenal cortex. Suggestively similar phenomena are the growth of pigmented nevi following treatment with corticotropin and the development of cutaneous tags during pregnancy and in the cushingoid state.

Malignant Neoplasms of the Skin

The effect of sunlight is to accelerate in the skin the appearance of senile changes. Probably if people lived long enough, cancer of the skin would ultimately develop in everyone regardless of quantity of exposure to the sun. Among those with chronically sunburned skin, however, cancers, both basal cell and squamous cell, appear before chronologic old age has set in, because the skin has attained the anatomic and biologic status of old age. Retired people everywhere notoriously overindulge a penchant for exposure to the sun in their hobbies, their relaxation, or their seeking

Fig. 1.—Cutaneous stigmata of aging. (a) Senile lentigines. (b) Seborrheic keratoses. (c) Hard nevi, flat wartlike lesions over back of hand. (d) Senile sebaceous adenoma (which is neither an exclusive prerogative of senility nor adenomatous), visible as a solitary pale nodule on the glabellar area.

for improved health. The decreased factor of safety of the elderly skin makes such a practice a potential hazard. If suitable measures were taken toward educating the public regarding the danger of indiscriminate exposure which leads to precancerous and cancerous changes in the skin, considerable progress would be achieved toward reducing the numbers of the commonest of all forms of cancer.

Most squamous cell carcinomas develop from senile keratoses, or, on the lip, from the equivalent leukokeratoses. Usually occurring on a part of the body which has suffered a lifetime of exposure to the sun, the lesion may appear as an indurated ulcer with broad pearly border, or as a verrucous or papillomatous lesion. Clinically, the ulcerative carcinoma is of greater malignancy than the verrucous or vegetative one; "a cancer that comes to you is less malignant than one that goes away from you."[5]

To be distinguished from low grade squamous cell carcinoma is the keratoacanthoma,[6] a skin-colored discoid or nodular tumor with large, central, penetrating, keratinous plug (fig. 2). In shape, keratoacanthoma resembles a doughnut with the hole occupied by friable horny material. Developing on the backs of the hands, the ears, the face or the neck, it asserts itself by rapid onset, spontaneous involution within four to six months, and a microscopic structure simulating squamous cell carcinoma grade 1. If it is of infectious origin, as seems likely, it shows a peculiar predilection for localizing on sun-damaged areas of the skin. Tenderness on pressure often evokes from the patient the opinion that a "sandspur" is embedded in the tumor, which of course is not the case. The lesion can be readily and cleanly shelled out with a curet, or it responds to x-ray therapy.

Basal cell carcinoma begins as a pearly or waxy nodule which ulcerates, bleeds and becomes crusted. It is recognized by its rolled, firm border traversed by delicate telangiectatic vessels. Metastasis almost never intrudes. If the tumor is pigmented, it may be confused with melanoma. In a small but appreciable percentage of cases mixed basal and squamous cell carcinoma arises, possessing the properties of malignancy of the squamous cell component.

Superficial epitheliomas are sharply outlined, scaling or crusted carcinomatous patches, with irregular configuration and a distinctive fine, threadlike pearly border. Of rather innocent appearance, the lesions are usually multiple (epitheliomatosis), developing over various portions of the body and especially the trunk as basal cell cancers. The faculty of ingested arsenic to stimulate the growth of superficial squamous cell carcinomas of the skin has long been known.

Fig. 2.—Keratoacanthoma.

Psychosomatic Aspects of Geriatric Dermatologic Problems

Patients of all ages display dermatologic problems based on anxieties and tensions. These factors of emotional stress may light up new symptoms of disease, or they may intensify existing symptoms. Once cutaneous (or any somatic) manifestations are established, they assume a dominant position in the patient's emotional life and to some degree reflect all of his emotional processes. The physician should be capable of recognizing the functional component of illness and know what to do about it. The thoughtful appraisal by Needles[7] brings a fresh and vigorous point of view to this subject.

Often the elderly person feels isolated and rejected. No longer the administrative head of his family, and frequently dependent upon children for support, which may be grudgingly given, his sense of security is deeply shaken. He has lost authority, importance, dignity and even self esteem. Insecurity is accentuated after the death of the marital partner or old friends, when the prospect of loneliness is stark and fearsome. Deprived of companionship, affection, and respect, all he has to look forward to is more of the same colossal bleakness, the chill feeling of helplessness and imminent death.

He feels sorry for himself. Those of his family about him, who should be his dearest, are engrossed in other interests. They may be impatient with his garrulousness and bored with his repetitious recital of events of the past. They are unforgiving of his forgetfulness and untidy

habits. Under these circumstances, and with an ever narrowing circle of activities to occupy him, he becomes introspective, and neurotic symptoms develop. Ordinary trifling sensations of itching are readily magnified under emotional stress. Too, the insomnia of advancing years increases the opportunities for concentrating on an itching skin. As the patient rubs and scratches, the traumatized skin responds by itching more severely and more extensively. Thus the basis for a persistent rash is established. The patient has gained attention, often coupled with annoyance, sometimes with sympathy, and the family is forced to assist him in seeking relief for his distress. His position of importance is once again restored.

Because the physician will often supplant the family in the patient's emotional attachments, the patient may try to produce all sorts of reasons for repeatedly visiting his physician. The physician can curb these tactics by a steadfast and positive attitude of control. Sympathetic and appreciative listening constitutes a large proportion of his treatment. The physician must give of his time, resisting the temptation to cut a monologue short. If old people bore him, he should decline their care. An optimistic approach, cheerful words, courtesy, and firm assurance will often win over even the depressed and sulking old man. Because the patient frequently has lost his sense of humor, if he ever had one, his illness, no matter how trivial, is never to be dismissed lightly. He is told that disease in older people is typically slow in healing, that impatience and discouragement are traits of the callow youth and immature adult, that he must accept illness philosophically and learn to live with it. Also, it is never supererogatory to reassure that cancer is not present. Meanwhile, strong and tactful efforts are made to broaden his sphere of interests, to minimize his preoccupation with his symptoms, and to salvage his self confidence. Neither by word nor act is he ever to be allowed to feel that he is being "brushed off" or medically abandoned, for then his sense of helplessness and hopelessness becomes haunting and tragic.

As with children, more can be gained by seeing patients of this type in the consulting room alone, away from other members of the family. Someone responsible, however, must be apprised of what the disease is, its prognosis, and what is to be done for it. Treatment instructions should be written, as a safeguard against the inattention, forgetfulness and misunderstanding of the senile patient. The instructions should be duplicated for the relative or attendant who will supervise the treatment.

Little Strokes

The pertinent observations of Alvarez[8] concerning the varied clinical effects of thromboses of minor arteries in the brain have convinced me that many persistent and peculiar dermatologic complaints of elderly patients may be actuated by "little strokes." Among symptoms of cerebral thromboses in the dermatologic sphere, this author described causalgic states, patches of cutaneous anesthesia, burning tongue or mouth, burning areas of skin, and other paresthesias. Often an elderly victim experiences intractable itching of a portion of the skin which cannot be accounted for by objective changes and which fails to respond to local treatment; or the sensation may be one of crawling insects, the resulting distress leading to severe excoriation of the skin and continual complaint, so that finally patient and family and physician all become exhausted.

Bizarre and atypical symptoms therefore suggest the possibility of injury to a part of the brain, particularly if preceded by sudden dizzy spells or an episode of blacking out. The possibility is heightened if there is evidence of mental, emotional and character changes and somatic signs of sudden aging. Treatment with iodides, low fat diet, and encouragement of mild activity, as recommended by Alvarez,[8] may accomplish more for the relief of these unfortunate victims than all sorts of topical medications and soporific drugs.

Autosensitization Dermatitis

The skin may become allergically sensitized to products of protein breakdown originating in and emanating from a localized lesion, whereupon an extensive or generalized eruption unfolds. It may start from a relatively insignificant patch of contact or other dermatitis. Among elderly people this phenomenon of autosensitization is common, especially as an accompaniment of chronic eczema of the legs. Termed "eczematid," it represents a reaction of cutaneous hypersensitivity, often with explosive force, in which absorption of pathologically altered autogenous tissue provides the antigen. Most frequently it is instigated by overtreatment of the primary eruption. Responsible also may be trauma, secondary infection, sunburn or other damaging influences.

Treatment of autosensitization dermatitis demands judicious care of the primary focus of dermatitis, for cutaneous "desensitization" usually parallels improvement of the original lesion. Cor-

tisone or its derivatives and corticotropin are invaluable for mitigating both the local and the general reaction of the skin. The prognosis for clearing is good in the mild cases. When there is severe and widespread eruption, or when the eruption has persisted for a long time, healing may be slow, or it may be incomplete, or the eruption may continue indefinitely. If recurrent episodes of autosensitization dermatitis occur, each attack is usually more extensive, more severe and more enduring than the previous one. Also, the older the patient, the more resistant is the eruption to treatment.

Some Problems of Treatment of Elderly Patients

Many drugs must be carefully and sparingly used in treating old people. Because barbiturates may be inefficiently broken down or excreted in the presence of liver or kidney disease, they may predispose to undesirably prolonged somnolence or confusion. Continued use of cortisone and related steroids may lead more easily to cardiac failure and osteoporosis in old patients than in young. Conceivably testosterone may incite the growth of dormant, or silent, foci of prostatic cancer, just as estrogens may accelerate the growth of cancer of the breast and uterus. Ergotamine is capable of producing vasospastic occlusion of arteriosclerotic vessels, with consequent gangrene of a part. Intravenously administered calcium has a digitalis-like effect and, in theory at least, may be harmful to the elderly patient, especially if he is under treatment with digitalis.

Local medications possess the same potentiality for inducing sensitization in the aged as in the young. The physician is urged to beware of topical anesthetics of the "caine" series (benzocaine, Nupercaine, Surfacaine), as well as topically applied antihistamine drugs, sulfathiazole, penicillin, and Furacin. He will do well to dilute all topical agents initially to a low concentration and apply them cautiously, always respecting the patient's complaint of discomfort from any medication. He should use keratolytics (salicylic acid, for example) and tars in low percentage, and habitually test a small area of the skin with a trial dose of stimulating medication before applying it widely. Incidentally, he must remember that gray and white hair may be undesirably stained by some chemicals such as resorcinol, Vioform, chrysarobin, and inorganic mercurials.

If he is wise, the physician will adhere to the dermatologic maxim that a drug too strong to be applied to the eyelids is probably too strong to be used anywhere else on the skin. He should be aware of the possibility of systemic toxic reactions from absorption through the skin of salicylic acid, phenol, boric acid, compounds of mercury, and other chemicals when spread over large surfaces. He should be alert to the danger of "therapeutic duplication"[9] for his elderly patients, who, having consulted a succession of physicians, may innocently continue to ingest and apply a large variety of medicaments ordered by all of them, to say nothing of medicaments "prescribed" by insistent friends and relatives. Finally, bowing to the inevitable, he must accept sensibly the fact that a fundamental attribute of old tissues is slowness of healing, and that the indispensable ingredient of successful dermatologic therapy, time, is extended proportionately to the age of the patient — and sometimes proportionately to the square of the age.

Disturbances of Nutrition in the Aged

As a result of faulty eating habits, unfavorable economic circumstances, dental abnormalities, mental or emotional disturbances, digestive diseases, debilitating illness, or alcoholism, chronic malnutrition is common among elderly people. Iron deficiency anemia occurs frequently. Reduction of proteins in the diet leads to derangements of the serum protein constituents, revealed chiefly by decreased albumen and increased total globulins. Although multiple vitamin deficiencies ought in theory to be almost constant handmaidens of an abnormal diet, seldom are these nutritional faults proclaimed by specific dermatologic manifestations. Geriatric nutritional eczema associated with hypoproteinemia is occasionally encountered in patients past middle life, consisting of edema of the legs and eczematoid dermatitis of the legs and other areas of the body.[10] Impaired healing of damaged tissue, such as vascular stasis ulcers or decubitus sores, may be due to lowered serum proteins, and occasionally a clinical reality, such as pellagra, makes its appearance; but by and large, true dermatologic evidence of nutritional and vitamin deficiency is rare in private practice.

Unfortunately, some dermatoses are often misinterpreted as nutritional diseases because of real or fancied similarity of symptoms. Thus, perlèche in elderly persons is almost regularly diagnosed as "cheilosis" of riboflavin deficiency, when usually dental malocclusion accounts for the circumstances which predispose to infection with Candida al-

bicans. Various forms of glossitis and gingivitis are ordinarily classed as evidence of deficiency of vitamin B complex. Indeed, practically all mucous membrane diseases, encompassing the range from benign geographic tongue to fatal pemphigus, are apt at one time or another to be diagnosed as vitamin B complex deficiency. Follicular hemosiderosis of the lower extremities (Schamberg's disease), the cause of which is unknown and the character of which is innocuous, is ascribed glibly to deficiency of ascorbic acid. Dry skin of senility is conveniently but unreasonably interpreted as a mark of vitamin A deficiency. The obvious inference from all of these remarks is that the more dermatologic diseases the physician is trained to recognize, the fewer become the occasions when vitamin deficiency will be diagnosed. Only then can he appreciate how nebulous and mythical are the entities which make up what are better termed the "vitamin pill deficiency" diseases.

Pruritus of Elderly People

Itching is a custodial privilege of the senile skin. This derives from the anatomic and biochemical changes of aging, which render the atrophic and arteriosclerotic skin inadequate to cope with the environment. Usually itching of the elderly skin can be attributed to the effect of excessive dryness, but this explanation is not invariably applicable, for sometimes itching is a dominating complaint of an elderly person whose skin fails to show significant signs of aging.

It is axiomatic that a dry skin itches. Dryness of the elderly skin is an accompaniment of the wasting of epidermal structures which results in diminished oiliness and in dehydration of the surface. A common deleterious influence is the abuse of bathing, particularly with strong soap and hot water in the cool season. At this time the dry air, out-of-doors as well as in heated houses, reduces sweating and abstracts moisture from the epidermal cells. Contact with woolen garments compounds the irritation as the short stiff fibrils of wool prick the skin like so many tiny barbs. To this may be added the irritative action of soap and detergent retained in laundered clothing and bed linen as a result of insufficient rinsing. The general use of rubbing alcohol reinforces the factors that defat the skin. A cycle of itching and scratching is set up, with eventual dermatitis and ensuing predisposition to complications such as pyoderma, overtreatment, and, worst of all, autosensitization. If a dermatologic disease pre-exists, such as varicose eczema, almost assuredly will it be aggravated.

Dry skin dermatitis should be unerringly recognized by the general physician. It occurs in young and old. Now and then it may appear as round, reddened and scaling patches on the lateral surfaces of the thighs or the sides of the arms, whereupon it is usually mistaken for ringworm and immediately overmedicated, with disastrous effect. Oftener the dry skin makes its appearance as a poorly defined, rough area of chapping, forming large polygonal scales outlined by a crisscross of red markings which may attain the depth of fissures. When the patient removes his clothing at bedtime, itching is initiated or is intensified, possibly by currents of air stimulating the nerve receptors, or from vasoconstriction (or reactive hyperemia) induced by change in temperature, or because of augmentation of cutaneous blood flow due to release of constricting clothing.

The suggestion has been offered that in dryness of the skin dehydration is the more important fault than defatting.[11] The practical significance of this observation lies in treatment, which logically should consist of tepid baths for restoring moisture to the surface epithelial cells, rendering them soft and pliable, as they are in summertime. The bath is followed immediately by application to the skin of a film of grease (petrolatum, lanolin, baby oil, vegetable oil) to retard evaporation. This dual procedure yields far more satisfactory results than does application of grease alone. High potency vitamin A has been recommended, but I am not convinced that, in most cases, it is of real value.

When an elderly patient complains of generalized itching and shows no evidence of objective changes, either as atrophy or dermatitis, to account for his discomfort, systemic diseases capable of causing such a symptom must be considered. Among these are diseases of the liver and kidneys, diabetes, lymphomas, neoplasms, cerebral arteriosclerosis, psychiatric disorders, and the untoward effect of drugs. If these conditions can be ruled out, the diagnosis of senile pruritus remains by exclusion. As stated previously, there is no entirely suitable pathogenetic explanation for senile pruritus. Occurring usually in men, it is treated with testosterone, orally or by injection, but the results are often unsatisfactory.

Possibly due to arteriosclerosis, senile skin may sometimes be the site of distressing paresthesias such as burning, tingling, or crawling sensations.

So intense may be the symptoms that the patient embraces the notion that he is infested with insects. He will pick from his skin a variety of "specimens" which he exhibits to the physician as insects, but which actually prove to be scales, crusts, clotted blood, balls of lint, and other debris of and on the skin. Such patients cannot be persuaded that their mementos are not actually parasites, and they continue to dig with the obsession of an archeologist on the verge of a monumental discovery. Sometimes the condition improves or disappears spontaneously; or, partial improvement, usually only temporary, may result from treatment with iodides, sex hormones, chlorpromazine, or niacinamide. One must not ignore the possibility that delusions of parasitosis may represent a schizophrenic disorder.

Among the most difficult problems in the entire realm of therapeutics is that of providing relief for the victim of generalized itching when the primary disease cannot be successfully treated. Management of intractable pruritus ("malignant itching") of jaundice, uremia, or one of the lymphomas, especially Hodgkin's disease, exemplifies this difficulty. Often little can be accomplished, yet nothing must be left untried because on exceptional occasions one procedure or another may inexplicably bring the reward of a surprising measure of benefit. In cases of pruritus of hepatic origin, methyltestosterone has been recommended; or ergotamine tartrate may be given subcutaneously, provided vigilance is exercised for danger signs of peripheral vascular spasm. When pruritus accompanies a systemic or neoplastic disease, procaine intravenously may provide temporary relief, or procaine amide (Pronestyl) hydrochloride may serve as well by mouth. Intravenous injections of calcium or strontium bromide are at times effective in these cases. Less often are other drugs of help, such as aspirin, Fowler's solution, antihistamines, or chlorpromazine.

"Essential" Anogenital Itching

An often tormenting disturbance of elderly people, anogenital itching stems from an extensive variety of conditions. When pruritus is present without eruption, detection of the cause may be eminently elusive. Etiologically important is abnormal dryness due to excessive bathing; or conversely, itching may be caused by insufficient cleansing and negligent hygiene. In every case, diabetes must be ruled out. Hemorrhoidal tags may trap stool and anal secretions and lead to persistent itching. Anal cryptitis and papillitis provoke itching by exciting hypersecretion of mucus. Ingestion of highly seasoned foods can result in burning and itching of the anal canal from condiments contained in the stool. Nylon underwear, due to the poor absorbency of synthetic fibers, may induce itching by allowing moisture to remain in prolonged contact with the skin. Dribbling of urine and incompetence of the anal sphincter soil the skin with irritating excretions which elicit itching. Harsh toilet tissues and frequent enemas commonly stimulate itching of traumatized anal and perianal skin. The cathartic habit is another frequent cause. Vaginal discharge due to Trichomonas vaginalis or C. albicans may be responsible for vulvar itching without eruption. Pinworms specifically cause itching of anal, perineal and vulvar areas when the parasites emerge at night. Large and ordinarily harmless comedones developing at the anal margin may produce troublesome pruritus until the contents are expressed.

Burning sensation of the scrotum is a common complaint of old men. Examination is incomplete if the possibility of a lesion of the cauda equina is not considered. As suggested before, in some cases of this type little strokes are probably the cause. Itching or burning of the genital and anal areas, in the absence of objective signs, signifies a psychogenic origin for the symptoms in a high proportion of cases. One might suspect fixation on the external genitalia as an expression of anxiety over failing sexual activitiy; or alternatively, it may be regarded as a reversion to genital fondling and masturbatory equivalents of early life. In some cases, cancerophobia is responsible for the abnormal attention devoted to the genitalia, whence the bizarre and vexatious symptoms.

Vulvar Lesions of Elderly Women

Kraurosis Vulvae.—Despite distinctive characteristics, kraurosis vulvae goes unrecognized with surprising frequency. Progressive thinning and shrinking of the vulvar mucous membrane effaces the normal folds and landmarks. The vaginal orifice becomes stenotic, the mucosa turns smooth, glistening, translucent and pale, and the attendant itching is more often intense than mild. Contrary to a widely stated belief, kraurosis is itself entirely benign; but leukoplakia may appear as an independent complication, bringing with it cancerous potentialities. Changing the name to chronic atrophic dermatitis is not warranted by the specific histopathologic picture of kraurosis;

nor should the disease be confused with physiologic senile atrophy.

Some cases of kraurosis respond to antipruritic management, including ointment or lotion of hydrocortisone, and the use of estrogenic hormones locally and systemically. The administration of thyroid and the administration of vitamins A and D have been advocated as supplementary measures. In mild cases, the disease may be arrested, and the tissues may even show evidence of partial restoration toward normal. Vulvectomy is required only if leukoplakia coexists and/or the pruritus proves uncontrollable.

LEUKOPLAKIA AND CARCINOMA.—Leukoplakia of the vulva establishes itself as white or gray patches in the region of the clitoris, over the inner surfaces of the labia minora, and on the perineum. The abnormal areas are thickened, opaque and furrowed; they feel rough and leathery to the touch. As on other mucous membranes, the appearance in leukoplakia of fissures, ulcers or inflammation implies carcinomatous transformation. Vulvectomy, and not conservative treatment, is indicated for vulvar leukoplakia.

Carcinoma of the vulva has been called the gynecologic cancer most characteristic of old age.[12] The tumor is able to spread rapidly and bilaterally through the rich lymphatic network to the inguinal and iliac lymph nodes. Treatment consists of radical extirpation of the vulva and lymph nodes on both sides. This is no lesion for x-ray therapy.

WHITE LICHENIFICATION.—As a result of rubbing and scratching of pruritus vulvae, the skin thickens and shows increased prominence of the mosaic of markings (lichenification, or neurodermatitis). Maceration of the surface imparts a whitish hue to the eruption, so that it may superficially simulate leukoplakia. Treatment of vulvar neurodermatitis includes correction of local or systemic abnormalities responsible for pruritus, application of suitable topical medication to procure relief of symptoms and healing of inflammation, and intelligent approach toward dealing with the emotional problems which dominate the background of most cases.

Oral Leukoplakia

Leukoplakia of the mouth is identified by flattened pearly or milky white patches anywhere on the oral mucous membrane. The lesions feel dry, stiffened and rough. Fissures, ulcers and papillary projections suggest cancerous change. Although often mentioned, evidence of the relationship of leukoplakia to syphilis, especially of the tongue, is seldom seen. Much more obvious is the etiologic role of irritation from dental defects and smoking. Leukoplakia is differentiated from lichen planus of the mouth, a disease no less common, by the delicate white annules, or streaks, or lacy network, or velvety discoid patches of lichen planus, as well as by the distinctive cutaneous papules — findings which should be familiar to every physician and dentist.

Treatment calls for strict attention to the hygiene of the mouth and dental care for calculus, cavities, malocclusions, and improperly fitting dentures. The use of tobacco in all forms must be prohibited. By these measures a mild case of leukoplakia may in time disappear. To satisfy the current therapeutic fashion, A and B complex vitamins can be given, for whatever help they are presumed to provide.

Superficial lesions of leukoplakia need no active treatment. Rough thickened plaques should be destroyed surgically or by electrocauterization. The presence of ulcers or vegetations nearly always denotes malignant transformation and necessitates adequate operative removal.

Some Vascular Diseases of the Aging and the Aged

The frequency of varicose veins of the lower extremities increases with age. As a consequence of chronic venous insufficiency, nutritional alterations of the skin initiate a series of events, the first of which is dermatitis of the ankles. Sometimes the eruption is minimal and recedes spontaneously or with treatment, leaving permanent residual pigmentation. If the inflammatory reaction is pronounced, or if the area suffers injury or recurrent infection, the poorly nourished skin fails to heal normally, and an ulcer is the result. Edema, scarring and inflammatory induration strangulate the cutaneous blood and lymphatic flow, and arteriosclerosis adds its unfavorable influence toward decreasing the blood supply further.

The most important item of treatment is exclusion of the incompetent venous system. This can be attempted conservatively by the use of constrictive bandages extending to the knee or by well fitted elastic stockings. Definitive treatment requires surgical attack, which, if lasting results are to be secured, should include ligation of the long saphenous vein at the saphenofemoral junction, ligation of the short saphenous vein (if this segment is incompetent, as it is in about 20 per

cent of cases) at the saphenopopliteal junction, and stripping of the entire length of the involved vein or veins. Injection of sclerosing solutions as exclusive treatment in these cases has no lasting value and is deservedly on the way out.

A varicose ulcer requires cleansing of the dirty base with moist compresses of normal saline solution, boric acid solution, or Burow's solution. If much necrotic tissue adheres, enzymatic debridement with Tryptar or Varidase is sometimes beneficial. Secondary infection may be treated by dusting with chloramphenicol powder as recommended by Robinson,[13] or with neomycin powder. Firm pressure applied over the ulcer with a pad of foam rubber under a knee length elastic support is one of the most effective methods for initiating healing of a stasis ulcer. Failure of conservative treatment creates the necessity for deep excision of the ulcer and contiguous scarred tissue, application of a split-thickness skin graft, and stripping of veins. For the dermatitis which surrounds the ulcer, dressing with a neutral oily medication is advised, such as calamine liniment (N. F.) or bismuth cream (bismuth subnitrate 4 per cent, zinc oxide 4 per cent, in equal parts of olive oil and solution of calcium hydroxide). Attention is directed again to the ease and frequency with which widespread autosensitization eruptions are produced among elderly people by overtreatment of simple stasis dermatitis. If itching is a pronounced symptom, and particularly if the area involved is small, hydrocortisone ointment is the remedy par excellence.

On the arterial side, ischemia associated with arteriosclerosis obliterans gives rise to modifications of the skin of the lower extremities, recognized as color changes on elevation and dependency, decreased temperature, atrophy, glossiness, loss of hairs over the toes, feet and legs, nail abnormalities (thickening, deformities, retarded growth), dry callosities on the plantar surfaces, torpid ulcers on the toes and heels, and gangrene. The frequency of obliterative arteriosclerosis in the elderly and the increased incidence of diabetes prompt the need for heightened consciousness concerning the care of the feet. Due to decreased tissue resistance, minor infections — particularly around ingrown toenails and interdigital fungous infections — may lead to complications such as cellulitis, lymphangitis, thrombophlebitis and gangrene. Hygiene of the feet includes gentle daily bathing, application of bland dusting powder, anointing with mild grease for dryness, proper trimming of nails, and in the case of dermatophytosis, the use of weak fungicidal preparations, of which diluted Whitfield's ointment (one-quarter to one-half strength) or undecylenic acid ointment are examples. Painstaking attention to treatment of callosities and corns is essential, but the patient's contribution to the care of these lesions should be restricted to thinning the keratotic accumulations with emery board, sandpaper or pumice stone. Cutting, paring or debriding by the patient with knife or razor must be explicitly forbidden.

Monilial Dermatoses of Older People

Levurids.—Some women at or beyond the menopause show a peculiar predilection for the development of extensive lesions which, because they resemble the eruption of seborrheic dermatitis on the face and scalp, have been unaptly termed (among various other names) generalized seborrheic dermatitis. Typically involved are the axillas, the inframammary, periumbilical, inguinal and perianal areas. Implication of the body folds has fostered the suspicion that yeastlike fungi play a role in the pathogenesis of the eruption, the cutaneous lesions depending upon a conjectured allergic hypersensitization to C. albicans, hence the name, "levurids." Nomenclatural confusion aside, the eruption is justly famed for its recalcitrance to treatment. It is prone to develop in obese women, to be complicated by bacterial infection, and to be aggravated by emotional disturbances. It fails to respond, whereas in contrast ordinary seborrheic dermatitis responds with almost pathognomonic alacrity, to topical medication with sulfur. Treatment includes a suitable weight reduction regimen and a trial of administration of estrogenic hormones. The mainstays of local treatment are mild tars, resorcinol, Vioform, mercurials and antibiotics. Cortisone and related steroids are effective for temporary control of severe cases.

Monilial Intertrigo.—Dermatitis of folds and flexures is common among older persons, and in many instances primary or secondary infection with C. albicans can be incriminated. The frequency of senescent obesity from overeating, of prediabetic abnormalities of carbohydrate metabolism in this age group, and of frank diabetes, accounts for the increased occurrence of yeast infections. The eruption may show itself in classical form as macerated erythematous plaques with scattered flaccid satellite pustules; or the features may be simply those of ordinary inter-

trigo, requiring microscopic examination for demonstration of Candida. The propensity of broad spectrum antibiotics for causing or intensifying this infection is currently recognized. Treatment entails reduction of dietary carbohydrate and control of diabetes if present. Among the most satisfactory antimycotic agents for topical application are weak salicylic acid or resorcinol lotions, diluted Castellani's solution, and suspension of mycostatin.

PERLÈCHE.—Dermatitis of the corners of the mouth is a common abnormality of elderly people.[11] Often incorrectly attributed to "vitamin deficiency," the eruption actually represents an infection which depends upon anatomic changes in the region of the labial commissures, such as exaggerated laxity and infolding of the tissues. Predisposing causes are loss of teeth, diminished elasticity of the skin, and abnormalities of occlusion. Among elderly persons with extreme abrasion of the occlusal surfaces of the teeth, as well as among edentulous persons wearing ill-fitting dentures, in whom resorption of alveolar bone has taken place, an overclosure of the normal relationship between the mandible and the maxilla prévails, so that the nose and chin encroach on each other's domain.

As the upper lip thereby becomes relatively elongated, it overrides the lower; in this manner infolding is created at the corners of the mouth. Accumulation in the fold of a continuous film of moisture and dissolved food material promotes the establishment of intertrigo. During sleep there is sagging of the face, and drooling saliva bathes the corners of the mouth throughout the night. Yeastlike micro-organisms will then proliferate, if conditions are favorable, until clinical perlèche evolves. Evidence of causal nutritional disturbance in these cases is rare. The foremost requisite of treatment is competent prosthodontic correction of the "bite" and restoration of the normal contour of the mouth.

Summary

Normal and abnormal characteristics of the aging skin are reviewed. Prominent among changes associated with aging are a variety of pigmented and hypertrophic lesions. Most of them are benign, some have potentialities for changing into malignant growths, and others are malignant from the start. Recognition of their distinctive features will avert errors in treatment, either as unnecessary surgery or unwise neglect.

Psychosomatic highlights color the dermatologic symptoms of elderly people. Possibly actual cerebral damage caused by little strokes may at times initiate bizarre and puzzling cutaneous manifestations.

An explanation for persistent and extensive eczematoid eruptions of aging people is offered by the concept of autosensitization, whereby products of tissue destruction elaborated in a localized inflammatory lesion ignite an explosive allergic reaction of the skin directed, in effect, against itself. This phenomenon is usually provoked by overtreatment with strong and injurious topical medication.

Nutritional inadequacy is synonymous with the faulty diet of many aged persons, but genuine signs of vitamin deficiency are dermatologic rarities. More often, specific dermatoses are fallaciously interpreted as products of avitaminosis.

Various causes of pruritus without obvious primary disease of the skin are enumerated and suggestions are offered for treatment. Clinical features and treatment of common vulvar lesions —kraurosis, leukoplakia and neurodermatitis— are outlined. Oral leukoplakia is also considered, because of its frequency and its propensity for cancerous transformation.

Attention is called to the problem of varicose veins among the aged, and to the ease with which an autosensitization eruption may emanate from a focus of stasis dermatitis. Ischemic changes caused by obliterative arterial disease prompt an exhortation for careful attention to hygiene of the feet in the older age group.

Levurids, intertrigo and perlèche, different cutaneous expressions of vulnerability to infection with C. albicans, are discussed with reference to pathogenesis, symptoms and treatment.

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Discussion

Dr. Wiley M. Sams, Miami: Without any pun being intended, I can say that Dr. Waisman has chosen a timely subject. The statisticians continually remind us that our population is an aging group, that the percentage of people beyond 50, and beyond 60, and beyond 70 increases progressively with the advance of medical science and the control of contagious disease. In addition to the change in numbers in the various age groups throughout the country, we must recognize that in Florida we are receiving, as permanent residents as well as on a transient basis, a proportionately higher number of persons from the older age group than is found in most other states. This increase is due to social and economic factors, to pension plans, and to old age security and insurance, which are increasing the ability of the retired person to live in a new community, where the environmental factors of temperature and climate tend to ameliorate some of the disorders which occur with the march of time, and which are aggravated by a more rigorous climate.

The impact of the cancer educational program is bringing an increasingly larger number of these older persons to the office of the physician, seeking treatment or diagnosis, not only for cutaneous malignant and precancerous lesions, but also for many other banal lesions which occur on the skin during the aging process. Many of these lesions are the cause of alarm to the elderly patient, yet are entirely benign, and Dr. Waisman has taken this opportunity to enumerate and describe some of the more common lesions of this type. Although the program does, in many cases, produce unnecessary concern and alarm in the apprehensive person, the total good which accrues from it in the early diagnosis of cutaneous malignant disease has been a valuable contribution. Early diagnosis has minimized the number of far advanced cutaneous malignant lesions, and has brought about the early cure of minimal lesions by expedient methods of therapy, which can be inexpensive and relatively free of risk and disfigurement.

The treatment of skin cancer offers problems which cannot be met by any single procedure, or any single plan. The patient with an incurable systemic disease will, in many cases, need no treatment. The same may be true of the octogenarian who has minimal early lesions and a short life expectancy. On the other hand, the young adult with an everted lip, or the laborer who must be exposed to the sun, is better treated by surgical excision and plastic repair, if such is needed, since scar tissue, or radiation therapy, often produces sequelae which may be troublesome when subsequently exposed to the sun or wind. Not only the age of the patient, but also the location of the lesion will determine what type of treatment will be most expedient and produce the best function, as well as cure the patient when a diagnosis of malignant disease has been established.

The skin of the older and the elderly patient is more subject to atrophic and regressive changes, becomes less well adapted in its protective functions, and is more likely to be affected by changes in temperature and humidity, by trauma, and by local applications, than is the case with a younger person. The skin which is thin and atrophic becomes dry and less elastic; slight trauma produces purpuric lesions which fade slowly. It is convenient to assume that many of these changes in the skin and mucous membrane are the result of vitamin deficiencies, but proof for such an assumption is more often than not entirely lacking. I am glad to hear Dr. Waisman again expose the fallacy of this contention. For the most part, the best that can be said for the vitamin therapy of such disorders is that it is free of danger, for it certainly produces no remarkable results.

Dr. Lewis Capland, Miami Beach: As with every good paper, it is difficult to do more than emphasize a few points which are brought out in the paper to be discussed. I think that the few points to be emphasized here are exceptionally important. One is that we must realize the various dermatoses as they occur in the aged last much longer than the expected duration of dermatitis in a younger person. A contact dermatitis which we would expect to last for two or three weeks in my age group, or younger, can be expected to last six to eight weeks under the same therapeutic regimen with the same control in a person who is 55, 60, 65 or 70 years of age. What this increased duration means is difficult to estimate. Maybe it is nutritional. Nutrition in the aged of course is particularly important because they have all kinds of queer ideas about what they should eat. They are all trying to live longer—whatever that is worth—and therefore are on all kinds of peculiar low salt diets, low protein diets, low everything diet. It is probably true that their nutrition is generally poor and therefore leads to a longer duration of an ordinary dermatitis.

Another factor which is exceptionally important is, as Dr. Sams mentioned, the evaluation of the scare of cancer. Frequently a patient comes to our office with a presumptive diagnosis of cancer of the oral mucosa. Any little change in the oral mucosa which has come to the physician's or the patient's attention is immediately diagnosed as precancerous or cancerous. Many changes, however, take place in the oral mucosa which are not of this nature. Not every keratotic lesion of the oral mucosa is precancerous or cancerous. A large number of patients have plates, and if we think an ill-fitting or a denture which is rubbing the buccal mucosa or the gingival mucosa is at fault, then to take away the irritating material and expect that mucosa, which has been irritated over a period of years, to respond by decreasing in its abnormality in two or three weeks is unfair. Here we must remove irritations over a period of weeks and months before we decide that something else must be done.

Another lesion of the oral mucosa which is of great importance is lichen planus. It is unusual to see lichen planus of the mouth without lichen planus of the penis in the male or the vulvar mucosa in the female and it is therefore worth while to examine those areas.

A simple procedure which is of no great difficulty to nondental personnel, is biopsy of the oral mucosa. That is a valuable diagnostic procedure which will expedite clearing up of all discussion about what the patient has.

Another troublesome disease which we see in our patients, particularly down here, is generalized yeast infections of the body as a whole, of the vaginal mucosa, and of the paronychial areas. One thought about recurrent paronychia which is of monilial origin is that the patient with a monilial paronychia may have a vaginal moniliasis and is contacting the paronychia from that angle. Of course, the old people wash dishes and get in detergents like the younger folks

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Surgical Aspects of Jaundice

Charles L. Wadsworth, M.D.
Fort Lauderdale

When confronted with the jaundiced patient, the surgeon first must decide if an extrahepatic type of obstructive jaundice is present, and second must determine, if possible, the cause of the obstructive process so that the results of surgical treatment can be evaluated and planned.

After the diagnosis of obstructive jaundice has been established, the surgeon must plan the preoperative preparation of the patient and the probable operative procedure to be used. Then he must carry the patient successfully through the postoperative convalescence.

Metabolism of Bilirubin: Mechanism of Jaundice

In order to understand the various mechanisms which produce jaundice, it is necessary to recall briefly the metabolism of bilirubin. Bilirubin is the iron-free derivative formed by the action of the reticuloendothelial cells on hemoglobin released from disintegrating red blood cells. When first formed, the bilirubin is bound to a protein of the serum and is known as bilirubin-globin, or "indirect reacting bilirubin," referring to the Ehrlich diazo reaction agent. Bilirubin-globin is then carried by the blood stream to the liver and is taken up by the liver cells and excreted by them into the bile canaliculi. During its passage through the liver cells, the bilirubin is somehow separated from the protein fraction and thereafter is known as the "direct reacting bilirubin."

This bilirubin passes through the bile ductal system into the intestinal tract, where it is acted upon chiefly by bacteria and converted into urobilinogen. The major portion of this urobilinogen is excreted in the stool. A certain portion of it, however, is reabsorbed and passes through the portal circulation to the liver and is almost completely excreted into the bile. A small amount, however, may spill over into the general circulation and is excreted in the urine.

It is apparent from this discussion that jaundice could be produced by a disturbance at any of a number of points in the natural process of the bilirubin metabolism. It is necessary therefore to have some clinical working classification of jaundice.

A most convenient and simple classification from this point of view is that of McNee who classified jaundice as (1) hemolytic, that is, jaundice due to excessive destruction of red blood cells; (2) hepatocellular, or jaundice due to liver cell destruction or inflammation; and (3) obstructive jaundice, which is due to mechanical blockage of the extrahepatic biliary passages.

In other words, jaundice may result from the production of bilirubin in quantities great enough to overload the excretory capacity of the liver cells, such as occurs in hemolytic types of jaundice; or from a dysfunction or destruction of these cells, which occurs in hepatocellular jaundice; or from a mechanical obstruction of the biliary ductal system, which is the obstructive type of jaundice.

Types of Jaundice

An understanding of the frequency of the various causes of jaundice is valuable in differential diagnosis. The hemolytic type is extremely rare, comprising only 2 per cent of all cases occurring in adults. The most common form of this type is the congenital hemolytic icterus, by far the most important in this category.

In the experience of most investigators, the hepatocellular and obstructive types of jaundice are encountered in almost equal frequency. Of the lesions which produce the hepatocellular type, virus hepatitis is by far the most common. It may be of the infectious variety, spontaneously acquired, or that transmitted in the blood, or blood products, known as hemologous serum jaundice. The second most common type of hepatocellular jaundice is cirrhosis of the liver.

Of the lesions which produce obstructive jaundice, gallstones with associated common duct stones and carcinoma of the pancreas and/or of the biliary ducts are certainly the most important. These are about equally common in occurrence and, together, cause well over 90 per cent of the icterus caused by extrahepatic biliary obstruction.

Strictures of the common duct are much less common as a cause of obstructive jaundice, being responsible for possibly 5 per cent of the cases.

The other causes of biliary obstruction are so rare that they do not require separate discussion at this time. The basic problem, therefore, when one is confronted with the patient with jaundice, is to make a decision as to whether or not

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a so-called medical or surgical type of jaundice is present.

Clinical Features

The age of the patient is a primary clinical consideration. Biliary obstruction of any type is rather rare in childhood. Icterus in the younger and middle-aged groups can usually be suspected of being hepatocellular in type. In middle life and beyond, parenchymal hepatic disease decreases somewhat in frequency, and the obstructive form of jaundice becomes increasingly more common. Common duct stones are more often found in middle life, and malignant obstructions are more prominent in older patients.

The previous history may be most significant. Inquiry should be made as to whether or not the patient has had previous surgery, particularly gallbladder surgery. If so, was the operation performed as an emergency, was the common bile duct explored, was it drained, were stones found in the gallbladder and if present, their number and size? Inquiry into the details of the postoperative course should cover whether or not there was prolonged drainage from the wound, whether or not there was a preceding jaundice or jaundice in the later convalescence, and also whether or not the patient received blood or plasma during the preoperative or postoperative care. This information is important in trying to evaluate whether or not the patient may have a homologous serum jaundice. The patient must be questioned concerning use of or contact with any other possible hepatotoxic drugs or chemicals, such as the arsenicals and carbon tetrachloride. Also, it is important to know whether or not the patient has had any recent contact with a patient recently having had hepatitis.

The prodromal symptoms are important. Of these, abdominal pain is particularly diagnostic if it precedes the jaundice. It is rare for a hepatitis to produce pain of considerable degree. Occasionally, however, a dull aching pain in the region of the liver is present.

Icterus on the basis of a stone in the common duct is characteristically accompanied by colicky pain, with a typical epigastric or right upper quadrant location, with radiation through to the back, or beneath the right scapula. It is only absent in 5 per cent of the cases with common duct stone, and these are called the silent common duct stones.

It used to be assumed that pain was either uncommon or absent in carcinoma of the pancreas or of the bile ductal system, but it is now generally established that 75 per cent of the patients with pancreatic or bile duct malignant disease have pain by the time they become jaundiced.

Many patients with hepatitis have prodromal symptoms of fever, malaise, loss of appetite, upper respiratory or digestive symptoms, mainly nausea, vomiting or diarrhea preceding the icterus.

Degree and Persistence of Jaundice

The degree and persistence of the jaundice often offer tremendous assistance in the differential diagnosis, particularly if the patient is seen after he has been jaundiced for some time. In common duct stone, the degree of jaundice ordinarily will not be as great as is present in obstructive jaundice due to carcinoma of the pancreas or the bile ductal system. Patients with a common duct stone will have what is known as the fluctuating type of jaundice due to the ball valve action of the stone floating up and down in the common duct, thus periodically relieving the obstruction. Those patients with the ampullary type of carcinoma, due to the erosion of the lesion, will or may have a fluctuating type of jaundice.

Usually, the patient with jaundice of the hepatocellular type will have initially a fairly high degree of jaundice, but its persistence is usually of short duration, disappearing or fading in 10 days or two weeks. Exceptions to this rule are observed.

Character of Stools

Also of diagnostic importance is the character of the stools. In biliary obstruction due to stone, the stools may become clay-colored at times, but may never become completely acholic. If they do, the acholia is only of short duration. Persistence of acholic stools is indicative of a neoplastic type of obstructive jaundice.

Physical Findings

A palpable gallbladder is a most helpful physical finding and is usually present in obstruction of the bile ductal system due to a neoplastic type of obstruction. Such lesions are primary carcinomas of the common duct or of the head of the pancreas unassociated with previous inflammatory disease of the gallbladder. This, of course, is Courvoisier's law.

Splenomegaly is helpful in a negative way. Obstructive jaundice is usually never associated with enlargement of the spleen, whereas in the hepatocellular type and occasionally in the hemolytic type, splenomegaly is present.

The lymph nodes, particularly the supraclavicular or Virchow's nodes in the neck, or the presence of a Blumer's shelf on rectal examination, may indicate the presence of a primary ma-

lignant process elsewhere in the body which has metastasized secondarily to the liver to produce the icterus.

The presence of ascites, edema of the lower extremities, and spider angiomata would make one lean towards the diagnosis of cirrhosis of the liver.

Laboratory Aids to Diagnosis

With the so-called liver function tests, the major biochemical findings in obstructive jaundice are those which result from interruption of the free flow of bile into the intestinal tract.

The flocculation tests, such as the cephalin cholesterol flocculation and thymol turbidity tests usually give negative to faintly positive results in obstructive jaundice if the patient is seen early, two or three weeks after the onset.

The quantitative van den Bergh reaction, since the bile has gone through the hepatic cells and lost its globin fraction, is regurgitated back into the blood stream and shows an immediate direct response.

There is a pronounced increase in the urinary bilirubin and an absence of urobilinogen in the urine if the obstruction is complete.

The alkaline phosphatase reaction will be elevated. There may be a prompt response of the prothrombin time towards normal after the administration of vitamin K. The total values of the blood cholesterol will be elevated with no change in its percentage of the esterified fraction.

Other laboratory aids in the diagnosis of obstructive jaundice are absence of bile in the stool, presence of bile in the urine to pronounced degree and positive results in tests for blood in the stools seen with ulcerative ampullary carcinoma and also carcinoma of the pancreas eroding into the duodenum, and in primary carcinoma of the bile duct.

Duodenal drainage may be carried out, and in cases of stone, characteristic cholesterol and calcium bilirubinate crystals will be seen; also, blood may be seen if ductal carcinoma is present. Papanicolaou smears may show malignant cells. The mere presence of bile will often answer the question as to whether or not the obstruction is complete.

Recently, the introduction of the intravenous injection of dyes, such as Cholografin, for visualization of the common bile duct in patients who have previously had the gallbladder removed, is a great aid in the demonstration of common duct stones or obstructions in the common duct producing icterus.

Also in the diagnostic work-up there should be included a complete roentgen examination of the upper part of the gastrointestinal tract, which in carcinoma of the pancreas will show either widening of the duodenal loop or displacement and compression of the stomach and duodenum by the malignant process in the pancreas if it is in the head. Use of the transthoracic blind Vim Silverman needle biopsy of the liver has its place in the case of jaundice in which the diagnosis is in doubt and the indication for surgery is questionable.

By using all of these means, a correct diagnosis in the jaundiced patient by close cooperation between the internist and the surgeon may be arrived at in approximately 90 per cent of the cases. There will be cases in which the diagnosis still is in doubt, and it is suggested by most observers that if doubt exists continued observation for a period of from three to six weeks in this type of case, with repeated clinical and laboratory examinations, will in most instances clarify the confusion as to the diagnosis.

Preoperative Preparation

Having arrived at a diagnosis of obstructive jaundice, the preoperative preparation of the patient is most important. The main complications of surgery in the jaundiced patient are hemorrhage and hepatic and renal failure. Vitamin K must be given to the patient with obstructive jaundice to correct the deficiency in the prothrombin production of the liver, because vitamin K is necessary for its synthesis. This is given parenterally for several days preoperatively and for seven to 10 days postoperatively. Also, the liver must be fortified by the ingestion of a high protein, high carbohydrate, low fat, high vitamin diet supplemented by either oral or parenteral ingestion of glucose or invert sugar to fortify the glycogen content of the liver.

Postoperative Management

In the postoperative management, if the patient has uncontrollable hemorrhage, due to lack of synthesis of prothrombin, whole blood transfusions are most efficacious in controlling this hemorrhage. Fluid intake must be adequate, and the glucose requirements must be met and covered with adequate intake of the B complex group of vitamins. Recent work has indicated that for impending liver failure, the daily injection parenterally of 300 mg. of thiamine along with 500 mg. of niacinamide in 5 per cent glucose in water or saline are most effective in combating this fatal complication.

Oxygen is used freely if necessary postoperatively. The protein requirements in the postoperative period must be met as most jaundiced patients are notoriously poor wound healers and eviscerations are common. Stay sutures are recommended in the majority of cases, particularly in those involving operations for malignant disease producing the obstruction of the biliary system.

High doses of vitamin C are believed indicated because they aid in the production of the intracellular cement substance which produces a strong postoperative wound.

A more detailed or specific type of management for each type of obstruction producing the extrahepatic type of biliary obstruction is not within the scope of this paper.

Summary

The mechanism and types of jaundice are reviewed. The clinical features, differential diagnosis and laboratory aids to diagnosis are discussed. Surgical aspects of the disease are given special consideration, and preoperative preparation and postoperative management also are discussed.

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ABSTRACTS

The Pathology and Bacteriology of Resected Lesions in Pulmonary Tuberculosis. By Henry C. Sweany, M.D., F.C.C.P., and Hawley H. Seiler, M.D., F.C.C.P. Dis. of Chest 29:119-155 (Feb.) 1956.

The study reported here has to do chiefly with some of the pathologic changes that take place following antimicrobial therapy in tuberculosis. The material presented is a representation of various types of healing, in some of which recovery would have occurred without resection, but in most of the cases arrest was brought about by surgical intervention following, and along with, antimicrobial therapy.

A pathologic and bacteriologic report is made on resected specimens from 34 patients who received some form of pulmonary resection. The most important observation was that rest and antimicrobial therapy not only clear up infiltrations in tuberculous cases but allow healing in over 25 per cent of recently developed advanced cases by filling in the cavities with granulation tissue and fibrosis, leaving only stellate scars. This group actually does not need surgery except to assure a shorter convalescence and protection against possibility of recurrence of the disease. Another 10 to 15 per cent may recover without surgery, but for many valid reasons given before, surgery is advisable. The remainder of seriously ill patients, about 60 per cent, need surgery for recovery, if recovery is possible. About half of these are sent home within six months to a year postoperatively with the disease arrested.

The bacteriologic findings in this series were not unusual. In only three cases was there a positive smear with negative culture. There were 15 negative and 16 positive cultures made from the resected specimens. The pathologic changes are discussed.

Evaluation of 13,797 Routine Cervical Smears in a Cytology Center. By Wayne S. Rogers, M.D., J. Ernest Ayre, M.D., and Barbara Millar, B.Sc. Obst. & Gynec. 6:487-492 (Nov.) 1955.

This report represents an analysis of 13,797 initial routine gynecologic smears sent to a cytologic center during the year of 1953. In almost all of the cases cervical cell scrapings with an Ayre spatula were used and two slides were submitted for examination. There was evidence of malignancy in 1.2 per cent of the smears and of a premalignant stage in 1.5 per cent; in 0.3 per cent malignancy was suspected. The high frequency of unsuspected malignant and premalignant cases detected in this study is regarded as significant.

Correlation with histologic findings may be difficult, the authors observe, but should be thorough before one advises a patient that she needs no further studies. They appeal for routine widespread use of cytodiagnosis as the only present feasible method of control of cancer of the cervix. It is their experience that the ability to detect the precancer cell complex in cervical cell scrapings provides a potent tool in cancer prevention.

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CARLOS P. LAMAR, M.D.....*Miami*
WALTER C. PAYNE SR., M.D.....*Pensacola*

DEDICATION CEREMONY

HOME OF THE
FLORIDA MEDICAL ASSOCIATION
735 RIVERSIDE AVENUE, JACKSONVILLE
SATURDAY, SEPTEMBER 15, 1956

PRESIDING ..... John D. Milton, M.D., Miami, Immediate Past President

INVOCATION ..... Paul R. Hortin, D.D., Pastor, Christ Methodist Church, St. Petersburg

INTRODUCTIONS ..... William C. Roberts, M.D., Panama City, President-Elect

REMARKS OF THE PRESIDENT ..... Francis H. Langley, M.D., St. Petersburg

INTRODUCTION OF THE BUILDING COMMITTEE—
Edward Jelks, M.D., Chairman, Jacksonville
Samuel M. Day, M.D., Jacksonville
Robert B. McIver, M.D., Jacksonville

RECOGNITIONS—
H. F. Saxelbye, A.I.A., Saxelbye & Powell, Architects, Jacksonville
R. J. Gallespie, Gallespie Construction Company, Inc., Jacksonville
Mary Ann Ballard, Interior Decorator, Homestead
Joseph Welker, Duval Landscape Company, Jacksonville

APPRECIATORY REMARKS
Honorable Spessard L. Holland, U. S. Senator, Florida
Homer L. Pearson, M.D., Chairman, Judicial Council, American Medical Association
Honorable Haydon Burns, Mayor, City of Jacksonville
Wilson T. Sowder, M.D., Florida State Health Officer

CUTTING OF RIBBON AND UNVEILING OF PLAQUE ..... Francis H. Langley, M.D., President

TOUR OF ASSOCIATION BUILDING

REFRESHMENTS ..... Arrangements by Woman's Auxiliary to the Florida Medical Association

Invocation

Paul R. Hortin, D.D.
Christ Methodist Church
St. Petersburg

ALMIGHTY GOD, FATHER OF US ALL

We quiet ourselves before Thee to worship Thee, and
To invoke Thy blessing.

We know that Thou hast created us, and not we ourselves.
We rejoice that Thou hast given to some among mankind
Skill in thinking after Thee
Thy thoughts of health and healing.

We thank Thee for
Physicians who have spared us from pestilence and epidemics
Doctors whose presence at our bedside
Is sweet with divine certainties.

We thank Thee for physicians and surgeons
Who have gone with our youth into Armed Conflict, and
With our loved ones into the valley of the shadow.

We thank Thee for men with blessed
Ministries in their minds and healing in their hands;
Men who are civic-minded in their communities, and
Pillars in their churches.
God bless them, everyone!

We pause also to pray for
The President of the United States, The Congressmen,
The Governor of Florida, and The State Legislators,
The Officers of the Florida Medical Association, and
The members of our own dear families.

OUR FATHER

For this auspicious occasion which has assembled us here,
We give Thee praise, O God of health and hope.
For President Francis H. Langley and many others,
Who by wise planning and generous self-giving, have
Brought us to this good day, we thank Thee.

OUR FATHER

Bless us in the dedication of this new
Home of the Florida Medical Association, and
finally
Bring us all at life's eventide
Home to eternal rest and reward.
In the name of our Great Physician, Jesus
Christ, Who taught
Us to pray together:

"Our Father Who Art in Heaven,
Hallowed be Thy Name;
Thy kingdom come;
Thy will be done on earth,
As it is in Heaven;
Give us this day our daily bread;
And forgive us our trespasses,
As we forgive those who trespass against us;
And lead us not into temptation,
But deliver us from evil;
For Thine is the kingdom,
And the power, and the glory,
Forever and ever. Amen."

Dr. Hortin

Dedicatory Address

Francis H. Langley, M.D., President

In humbleness of spirit, yet with a deep feeling of exaltation, of pride, and of inner satisfaction because of a cherished goal attained, I appear publicly for the first time today in the exercise of my official duties as President of the Florida Medical Association. I count it a signal honor to have a part in the dedication of the permanent home of our Association. This imposing edifice with its beautifully appointed interior is indeed a home, one that is commensurate with the Association's importance and stature in the general picture of this great state.

Here at last is our home on a leading thoroughfare of the Gateway City, nestling among moss-draped oaks in the shadow of a beautiful new bridge across the mighty St. Johns River. We have come today to dedicate this home to organized medicine and the standards it is pledged to uphold, to dedicate it to those who had the foresight, the energy and the courage which made it possible, and to dedicate it to the welfare of the people of Florida, whose health our members are privileged to safeguard. It is peculiarly fitting that the city of its birth should become the permanent home of the Association. At the instigation of the Duval County Medical Society, the Florida Medical Association was founded in Jacksonville on January 14, 1874 at the home and office of Dr. A. S. Baldwin, its first president. This mansion stood on the northeast corner of Adams and Laura streets, now in the heart of the city's business district, little more than a mile from this building, for which we have waited 82 years. Meanwhile, the Association has for many years maintained headquarters in downtown Jacksonville.

Here is the workshop of the 3,000 members of their respective county medical societies who comprise the scientific, public service and fraternal organization which is the Florida Medical Association. In this building that so admirably reflects in its physical features the dignity, the honor and the integrity of the medical profession, there is housed a veritable beehive of activity which, in turn, reflects the myriad activities of this virile, aggressive state medical society. This excellent plant, with adequate space and every modern facility for expediting the work of a loyal and efficient staff, is in keeping with the ever broadening scope of the Association's interests and accomplishments. It provides an efficient workshop in which to perform the many services of our society for many years to come.

Here in this ideal setting for a home, the officers, the Board of Governors, the committees and other groups will meet to coordinate the activities of the Association and promulgate the policies determined by the members of this truly democratic organization. In this market place of professional ideas and administrative service to the public and to the profession alike, there will take shape many projects of far-reaching significance throughout the state. Florida medicine's new home fills a great need for appropriate administrative headquarters.

Here in this beautiful building are centered our multitudinous public relations activities. This vital program, designed to be mutually beneficial to the public and the profession, is a measure of the progress of the Association in recent years which augurs well for the future. The spacious quarters devoted to these activities now become the focal point of legislative problems, of health education, and of a thousand and one other services to the public and to the members, individually and collectively.

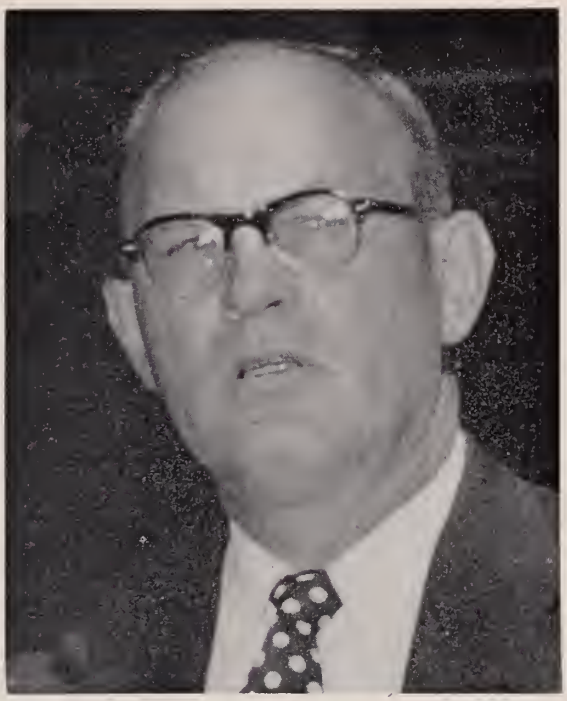
Here in this magnificent plant The Journal of the Florida Medical Association has found asylum, along with the Association's other publication activities. In no department does this modern establishment fulfil a greater need than in this division of activity which carries the voice of the Association to every member.

Here in our new home we celebrate on this memorable occasion a particularly notable milestone of progress in the long history of our Association. It is our privilege and pleasure to have distinguished representatives of the Florida Bar and the several allied professions join with us in this service of dedication. We recognize this expression of their interest with gratitude and take this opportunity to express genuine appreciation of their cooperation in dealing with the mutual problems that beset us in these times.

Here is a structure that is already more than a building. Here is a permanent home admirably suited to the needs of the Association, but it is even now more than that. Here is a symbol — a tangible expression of medicine's great intangibles. The casual passer-by doubtless will see it as a

symbol of material growth in a rapidly expanding metropolis. To the more discerning observer, to us in medicine, to our friends in kindred professions, indeed to all who are cognizant of our aspirations and our goals, it becomes far more than masonry and steel, far more than a memorial to the Association's achievements, far more than a monument to individual effort, far more than just a home for the Association.

Here is a beacon of service to all the people of Florida. Here is a torch held high to light the way and smooth the road for suffering humanity. Every single member of the Association takes pride in being part owner of this nerve center of Florida medicine, which embodies the essence of all that has made our profession great and indispensable to the welfare of our nation. Here under this roof are preserved the best traditions of a great profession; here is complete dedication to the promotion of scientific medicine and the betterment of the public health; here is a tangible reminder of the doctor's dedication to his calling, that of service to every Floridian. Here, too, is the cornerstone of medicine's new philosophy which prescribes a potent role for every physician in the social and economic affairs of our land. All of Florida may rejoice that the medical profession in this state has seen fit to build a structure which signifies the increasingly important role of medicine in the care of the people as social beings in need of the art as well as the science of medicine.



Dr. William C. Roberts, of Panama City, President-Elect, introduced Dr. Francis H. Langley and the other speakers on the program for the Dedication Ceremony.

The labor of love is done. The building is finished, but its contribution to society is only beginning.

National Aspects of Medical Legislation

The Honorable Spessard L. Holland
U. S. Senator from Florida

We are all here today to congratulate the officers and the members of our great state medical association who, by working together and contributing jointly, have made possible this fine building. I am sure that it is adequate architecturally and from the standpoint of construction, arrangement, decorations and beautification. We all join in complimenting and congratulating all of those who had a part in bringing about this fine development. I am sure that I also speak for all of you when I say that we all hope the fruits to come from the use of this building will justify and even exceed, if possible, all of the fine promise which is given of availability and adequacy for the rendition of good service. Everybody who is interested in it is hoping that out of this highly adequate center may come even better leadership in the field of public health and the field of medicine and all of the fields in which doctors are interested — leadership of our people, leadership of their profession and, I hope, reasonable guidance of those who represent all of us at Tallahassee and at Washington, because in a field like this naturally legislators and executives both look to those who are trained in a field of such high science for their expressions as to what it is that needs to be done in the fields that are so ably served by them.

The medical profession is one of our oldest and most honored groups, ranking only after ministers of the gospel of the various faiths who seek to serve the spiritual side of the life of man. Next only to that group, and closely behind it, is this great group of physicians who serve the bodies and the minds, the health and the ambitions, and

all that goes with the real health of men, women and children throughout the civilized world. Certainly we here in Florida are sure that we have fine representation from the great group of healers who comprise the members of the American Medical Association among the 3,000 members of the state medical association. Just as it is true in other fields that we have attracted leading builders and leading participants in almost any profession or business by reason of the opportunities here, we have likewise attracted to us large numbers of leading, aggressive and highly trained members of this great profession. We are glad that you are here, we are glad that you are pointing this way to greater service for yourselves and for us, and we congratulate you with all our hearts.

With regard to your interests which will center here, I have noted with a great deal of satisfaction in recent years that while you still make a matter of primary concern those things that directly touch your profession and its proper practice, you are also evidencing interest in other vital matters of general, social, economic and business importance. One reason I am glad that is the case is that a great group of men who, with all their learning that comes from books, have to learn above all things how to analyze human beings and how to figure out what is happening beneath the exterior appearance of each of us, must have some ability to analyze the needs of our people and be able to express those needs in recommendations. In so stating I am speaking for all of the members of your delegation in the Congress. Having been a member of your state senate, I am sure I can speak for all members of the state legislature and the executive branch of our government in saying that we invite and appreciate your recommendations. We do not always agree to abide by them, though I think in the main most of us do and most of us have. We recognize them, however, as coming from an exceedingly well informed source that has a great opportunity to know how to analyze human nature and to determine what are the needs of our people.

I have observed since I went to Washington even more than before, what a tremendous field of activity directly concerns you. For instance, I got the report from the highly efficient Washington office of the American Medical Association as to the legislation which was introduced in this 84th Congress, that is last year and this year, directly affecting you and the fields which you

Members of the Building Committee (left to right), Drs. Robert B. McIver, Samuel M. Day and Edward Jelks, all of Jacksonville, were presented prior to the address by the Honorable Spessard L. Holland.

Principal speakers on the program for the Dedication Ceremony were (left to right), the Honorable Haydon Burns, Mayor, City of Jacksonville; the Honorable Spessard L. Holland, U. S. Senator, Florida; Dr. Homer L. Pearson, of Miami, Chairman, Judicial Council, American Medical Association, and Dr. Wilson T. Sowder, of Jacksonville, Florida State Health Officer.

serve. I found to my surprise that 571 measures were introduced in either the House or the Senate in that two year period directly affecting the fields in which your activities primarily lie. Of this number, 25 were enacted, and my letter from the director of the Washington office stated with some pride that most of the measures enacted were warmly supported by the American Medical Association. I shall mention only one or two because I want to make an observation with reference to them.

One is the extension of the doctors' draft. I know perfectly well that many of you feel, and with great propriety, that you are rather singled out as a group in being subjected, at the ages specified, to a draft. At the same time, however, it has proved highly difficult for our armed services to be properly served in time of peace, in particular by members of a profession who exist apparently in not sufficiently large number now to serve, and have sufficient time left over, our rapidly growing civilian population. May I express to you my appreciation for your having gone along in the extension of the doctors' draft act, which I know was not particularly liked by many of you? My particular appreciation goes to those eminent doctors in this state, headed a short while ago, and I suspect still, by Dr. J. Rocher Chappell down in Orlando, and by various others in each area of the state, who have administered — and it is really a difficult task to administer—that act.

Another act that was passed this year was known as Public Law 569. It included some provisions which I believe you would have voted for if you had been there because, after all, that act in its essence was trying to make service in the armed forces more acceptable to persons with families so that they would feel that they had a future and that their families would be well cared for and that they would not have to feel ever that they were being neglected in any essential phase of their activity. One of the principal provisions of that act is to make medical services available to all dependents of personnel in the military service. It is questionable; we could argue about it on both sides, but I hope that you will agree with me that able and patriotic persons representing you and me on the armed services committee of both houses of the Congress came rather inescapably to the conclusion that in order to have anything like the necessary holding power and attracting power to get and to hold on to personnel of the type we need so badly in the armed services — incidentally, now we need some of the most highly trained technical men in our nation

in those services — that that legislation was necessary.

Of course, the most highly debatable measure was the social security extension or enlargement. I see here before me a distinguished young doctor who honored us by calling on us several times up at Washington and acquainting us rather fully with your views. We were not all in accord with the provisions of the law which were included. For instance, I was not in accord with the provision covering disability. Nevertheless, when the Congress speaks and when our nation speaks in the way it is set up under our constitution for the expression of our people, that becomes the law. It has been particularly gratifying to me to note that those of you who knew most about this legislation and who regretted most the inclusion of that particular provision, have been the first to come forward eagerly to help work out a fee schedule for public service recipients. The setting of fees was necessary and could not have been done with satisfaction to all concerned except with the cooperation of the very ones — and they did cooperate — who did not want that provision in the act.

A word or two is in order about Florida and its appeal to more and more, better and better, finer and finer medical personnel and medical facilities. We are now growing at a faster rate than any comparable state in size in the nation. Only two states, I believe, Nevada and Arizona, are surpassing us slightly in percentage of growth. With that growth come not only the many new residents who have to be served by you, but also the people who come, some for help, some just for pleasure, but many to look over our fastest growing state. Numbering more than five million just last year, these visitors make up the greatest group of transient citizens entertained by any state of the nation. We realize that in many cases they have to turn to you for service in emergency and highly necessary matters while they are here as our guests.

To me it seems that that fact alone would make of this state a rather key state in your profession and its practice. Add to that consideration the fact that two new medical schools are arising, and I hope they are going to be great ones; the fact that we already have three veterans hospitals with another one badly needed—a neuropsychiatric hospital which I think we shall get shortly; the fact that we have some 10 or 12 armed services hospitals in our state; the fact that we have a most alert State Board of Health with its services that have to deal not only with problems that begin here but with problems that are brought in by our hundreds and thousands of visitors from various parts of Latin America; the fact that we have tied in so closely with the Public Health Service that we have been able to keep here one of its eminent and distinguished members, Dr. Wilson T. Sowder, our State Health Officer. During the years that I was serving you over at Tallahassee, we were having a bad time year after year getting his stay extended so that he could continue to serve us here in Florida. I do not know how it has been done since that time, but I am glad that it has been done.

The whole picture of the combined county health units, State Board of Health, Public Health Service, schools, veterans hospitals, service hospitals, hundreds of civilian hospitals — we have been one of the largest recipients of aid under the Hill-Burton Act for aid in constructing new hospitals and clinical and laboratory facilities — all of these considerations, it seems to me, tend to point up the fact that a building such as this does have a tremendous field of service. I am sure that it will serve in such a way as fully to live up to the expectations which all of us have for it. So I am happy to be here to speak for our delegation, represented today by Congressman Bennett and myself.

May I say to you as a trustee of Emory University, where we have a great medical institution through which we are trying to serve not only the state in which it lies but all the states in this region, that we are looking for ever better cooperation and ever finer service and leadership from those who practice with such a high degree of conviction and devotion here in Florida? Best congratulations and good wishes to you, the medical profession of this state, which in so many ways is the key state of all this region, and one of the key states, if not the key state of the nation, in the field of public health and medical service.

Invitation

It is hoped that members of the Florida Medical Association will visit their headquarters building at 735 Riverside Ave., Jacksonville. The hours are 8:15 a.m. to 4:45 p.m. daily and Saturday 8:15 to 12:00.

Near the end of the Dedication Ceremony, Dr. Francis H. Langley, President, unveiled the plaque mounted on the northwest corner of the building, which states that the building is dedicated by Association members to the advancement of medical science and medical services in Florida.

Representing the American Medical Association

Homer L. Pearson, M.D.
Chairman, Judicial Council

To represent the American Medical Association is in itself a great honor, and to be able to speak as one who has been privileged to be a part of and also witness the growth of organized medicine, not only in Florida but over the entire nation, makes me proud and happy. Many of you gathered here not only have witnessed this growth, but have contributed much of your time, energy, imagination, and ability to its success.

The American Medical Association has increased not only in stature but in every proportion, and this over-all progress has been due to the sound thinking, the far reaching vision and planning, and the energetic action of its component and constituent county and state associations.

When we remember that the American Medical Association is only a federation of state and territorial medical associations, all with equal representation in its policy-making body, and when we realize that the organization and its policy are the result of careful and considered opinions of representatives elected by you and me, it becomes evident that grave responsibilities rest on us, the medical doctors of this and all the states of this nation, for the avowed purpose of this great organization is to promote the advancement of medical knowledge and the improvement of medical care for all our people.

This building which today is being dedicated is but a testimonial and declaration to the people

of Florida and this country from the medical doctors of this state, of their never ending struggle against pain and disease and of their continuing efforts to bring peace, happiness, tranquility, and health to our people.

As the official representative of the American Medical Association, I bring greetings and wish for you continued success, happiness, and long life. Let us continue our labors, hand in hand, and with one accord.

May we as we dedicate this building, rededicate our lives to this great task before us. May we walk in the ways of the Lord and strive to follow in the footsteps of the Great Physician, so that when we finish our labors here, we may enter with the good and faithful servants into everlasting life.

Greetings from the City of Jacksonville

The Honorable Haydon Burns
Mayor, City of Jacksonville

I represent the quarter of a million citizens of this city in expressing to the members of the Florida Medical Association our extreme joy and our gratitude and appreciation, first, for their having selected Jacksonville as the site for this magnificent building; second, for having selected such a prominent place in our community for its construction, where we may have the advantage of pointing to it with joint pride with you, as we show the other fine attractions of our community; and, third, for having built such an efficient and yet such an attractive edifice to add to the other improvements of our community. We are mindful of the fact that the Florida Medical Association came into being here in Jacksonville some 80 years ago, and we feel that your permanent headquarters here will add to that beginning so that we not only may boast that we were the city of its beginning, but also may take pride that we are the city of its present and continuing service.

I assure you that the citizens of Jacksonville are mindful and appreciative of the fine, unselfish service that is rendered by the members of your Association. In the dedication of this building, it is our wish that God shall continue to guide your hand that you, through your profession and with His guidance, shall be able to continue to lead us in a state of health as well as one of prosperity. Our compliments, our congratulations, our best wishes for continued success in this, your new headquarters.

Appreciatory Remarks

Wilson T. Sowder, M.D.
Florida State Health Officer

I appreciate this opportunity to participate in the dedication of this building for the Florida Medical Association, of which I am merely one proud member. Today, I represent the State Board of Health and come to express the appreciation of my board and all the members of our staff for the fine cooperation over many years that the Florida Medical Association has given us.

The cooperation and assistance that have been given to the State Board of Health began long years ago. Many people do not realize that physicians in the organized medical profession in Florida have done a wonderful work not only in raising their own standards, not only in taking wonderful care of their own particular patients, but also in the over-all field of public health. The individual physicians have extended their interests beyond their own offices and have interested themselves in the over-all affairs of public health in this state and in the nation as well. The Florida Medical Association, I understand, is 82 years old. Eighty years ago, the Association asked the legislature to set up a State Board of Health. There was none at that time. The Association asked the legislature to appropriate the sum of $1,500 for the purpose, but the records show that the legislature, being of an economical turn of mind at that time, decided the project was too expensive and postponed it for another 10 or 15 years. That was the first expression of the interest of the organized medical profession in Florida in public health and in the State Board of Health.

Many, many other expressions have been made since that time, but I shall point out only a few recent examples that I think are outstanding in Florida and in the country. In 1945, even before

Formally opening the building, Dr. John D. Milton, of Miami, Immediate Past President, and Dr. Francis H. Langley, President, cut the ribbon at the termination of the Dedication Ceremony.

I came here, the Florida Medical Association, through its House of Delegates, went on record as being concerned with the problem of persons with cancer who were indigent and had no way to have their hospital bills paid. As a result of the Association's recommendations, a program was set up through the State Board of Health for the care of indigent persons with cancer. In the last two or three years, as a direct result of the interest of the Florida Medical Association, a program has been set up through the State Board of Health for the hospitalization, the payment of hospital bills, by the state and by the counties for all indigent persons who are not otherwise provided for by some other program. Largely as a result of the interest of the Florida Medical Association, the State Welfare Board has become interested in the same subject and has taken advantage of unexpended state and available federal funds to set up a much larger program, which will go a long way toward taking care of the hospital expenses of poor people in Florida who are unable to take care of themselves. Those are three examples in brief of the interest that this Association and its members have taken in the health of people who do not come into their offices and pay them. It is an indication of the fact that the Florida Medical Association is one of the principal public health organizations in the State of Florida.

The close association of the State Board of Health and the Florida Medical Association has been greatly advanced because of the work done not only of all the members of the Association, but in particular by some outstanding members. Dr. Stewart Thompson, who was for many long years managing director of this Association, began his career in Florida at the State Board of Health. For several years he worked with both agencies and finally went full time with the Florida Medical Association. Dr. Robert B. McIver, who is on the building committee and who served as secretary of this Association for many, many years,

was also on the State Board of Health for a good many years and helped to cement the good relationships between the official state health agency and organized medicine in Florida. Dr. Shaler Richardson, the Editor of The Journal of the Florida Medical Association, was at one time a member of the State Board of Health. Dr. Herbert L. Bryans, a member of your Board of Governors, has for many years been president of our board. These men have, I think, made Florida an outstanding example of how the state government and the organized medical profession can get along together, how they can get along together without suspicion of each other, and how they can work cooperatively for the health of all the people and raise the standards of the profession and yet do so without interfering with individual rights and the private practice of medicine.

Now I want to express my appreciation to Dr. Milton for the kind words he said to me and also to Senator Holland for saying the kind things he did about me. Senator Holland directed your attention to the fact that I have been on leave of absence from the U. S. Public Health Service in Florida for the past 11 years. I joined the U. S. Public Health Service in 1934 and today I was to be in Atlanta, Ga., on a new assignment because the Public Health Service gave me an ultimatum that I either come back to them or sever my connections. Yesterday I sent in my resignation to the U. S. Public Health Service, choosing to remain here in Florida. I would not have taken this step if I had not believed that I could look to the Florida Medical Association for continued support of the public health program in Florida and for the fine spirit of cooperation that we have had in the past.

American Medical Association Clinical Session Seattle, November 27 - 30

This year's Clinical Session of the American Medical Association will be held in Seattle the last four days of this month. Opening on Tuesday, November 27, this meeting with its many attractions will draw physicians from throughout the nation to the far Northwest. Seattle's Civic Auditorium will be the center of activities, for the scientific sessions will be held there and exhibits will be displayed in its spacious quarters. It is easily accessible from downtown hotels, and transportation to and from the meetings will be available. A cafeteria will be in operation in the auditorium for midday meals.

The Olympic Hotel will be headquarters. The sessions of the House of Delegates will be held there and also the meetings of the Board of Trustees, councils and reference committees.

Subjects for the scientific program have been carefully chosen to be of interest and practical value to the general practitioner. There will be panel discussions, individual papers, motion pictures and closed circuit television clinics. Panels of physicians prominent on the national scene and in the Northwest will consider 20 topics, including hypertension, hemolytic anemia, prenatal care, problems of aging, epilepsy, low back pain, disease of the liver and vascular disorders. Eminent medical educators and practicing physicians from all parts of the country will present 45 papers on such subjects as fluid balance, urologic problems, office psychiatry, varicose veins, fractures, diabetes and heart disease.

Clinics are planned on block anesthesia, treatment of burns, bleeding problems, intestinal obstruction, caesarean section, hand surgery, vein stripping and other subjects. The television clinics will include both operative and nonoperative programs, and an excellent selection of medical motion pictures will be shown.

The usual large number of scientific and technical exhibits have been arranged. They promise to be as interesting and varied as in the past.

Socially, the highlight of the Clinical Session will be a banquet and entertainment in the headquarters hotel on Wednesday night, November 28, for the officials, the Board of Governors and the members of the House of Delegates and their wives. Elaborate plans for Auxiliary activities also have been made, which include sightseeing tours and other events.

For three days during the meeting, the prepaid medical service plans of Washington, Oregon and Idaho will conduct a hospitality suite in the grand manner. In addition, they will present an exhibit of their services to the public.

After the meeting closes, physicians and their wives are invited to take a Hawaiian vacation. Arrangements have been made for two different air cruises to Hawaii direct from Seattle. They include air fare, accommodations at first class hotels in Honolulu, sightseeing to the various islands, a yacht cruise of Pearl Harbor, a native "luau" and the services of experienced travel representatives. Details may be obtained from Mr. Ralph W. Neill, the executive secretary of the Washington State Medical Association, 1309 Seventh Avenue, Seattle 1.

On the Networks

Medicine has a big role in 1956-1957 television programming. Most of last season's shows pertaining to medicine or health are continuing to appear. Others are now on the air, or are being prepared for midseason presentation.

A notable new 28 minute television film, titled 'Even For One,' is designed to emphasize the human side of medical practice. It is now in production and is scheduled for release on Jan. 1, 1957. In announcing this third motion picture in a series of half hour television programs produced by the American Medical Association for use by local and state medical societies, Leo E. Brown, its Director of Public Relations, commented: "So much television fare reports on the technical side of medicine — scientific advancements, new techniques, surgical skill — that the human side of medical practice is thrown out of its proper perspective. In "Even For One" we hope to show TV audiences the personal qualities of a practicing physician — his devotion to duty, his integrity and, above all, the value of his judgment." Advance bookings for placement after January 1 on local television stations can be made with the TV Film Library of the American Medical Association.

"On Impact," a 14 minute film portraying the role medicine is playing in prevention of automobile accidents, was released last month by the American Medical Association and the Ford Motor Company. It was produced for use over television on public service time or for showing to schools and club groups. This documentary presentation incorporates information on auto crash injuries presented at the annual session of the American Medical Association last June and an analysis of recent safety improvements in motor vehicle design. Through a special grant by the Ford Motor Company, a print of "On Impact" is being mailed to each television station in the country and may be retained in the station's file for repeat use. Prints for medical society use are available through the TV Film Library.

"Medical Horizons" returned to the air in September, at 4:30 p.m. EDT on Sunday, over the ABC television network. Presented by Ciba, in cooperation with the American Medical Association, this popular presentation will have a run of 39 weeks, featuring live reports from America's leading laboratories, hospitals and clinics.

The next "March of Medicine" presentation is scheduled for this month. This hour-long report, in color, on medical missionaries in Africa's Belgian Congo will be seen over the NBC television network at 9:30 p.m. EST on Tuesday, November 27. It is produced and sponsored by Smith, Kline and French Laboratories in cooperation with the American Medical Association.

"Baby Time" is a 15 minute filmed program on infant care, featuring Dr. W. W. Bauer, Director of the Bureau of Health Education of the American Medical Association. Shown in 11 cities in the fall, including Miami and Tampa in Florida, it is now available to individual stations throughout the country for local sponsorship.

Feature stories about medicine and health, some of them produced by Howard Whitman, are now being used in a new part of the program called "Live a Better Life." Among them are stories about heart disease, polio and a family's adjustment to illness in the home.

The television adaptation of radio's popular "Doctor Christian" is a new show with a medical theme which promises to make a big impact in the 1956-1957 season. Producers of the program, Ziv TV, have announced that the syndicated film series will be seen in 103 cities, covering 60 per cent of the nation's 35 million TV homes. The title role, created by the late Jean Hersholt, will be filled by MacDonald Carey.

"Dr. Hudson's Secret Journal," introduced last year as a syndicated series used by individual stations with local or regional sponsors, has received phenomenal ratings in many cities. Additional stories are being filmed in the "Dr. Hudson" series.

Watch for a new medical detective series. "Probe" is being developed by CBS-TV in cooperation with the American Medical Association. Check your local stations for the schedules of these various programs.

OTHERS ARE SAYING

Editorial

If we were to suddenly find ourselves in the middle of the Pentagon, expected to fit somewhere in the routine of things, we would probably be no less confused than many patients who suddenly regain consciousness in the middle of today's complex hospital.

Breakfast withheld, blood samples drawn, urine specimens demanded. Back and forth to X-ray. Drink no water. Drink all the water you can. Pills, pills, pills. Personnel are rightly reluctant to discuss these things since these are the responsibility of the attending physicians.

In this enlightened era we are finding our patients better informed every day through the Reader's Digest and the Ladies Home Journal. Since the patient is better informed about medical advances, what happens to him in the hospital, if unexplained, may bewilder him. When the patient knew nothing about sed rates and Pap smears or path reports, he didn't sweat out a cancer diagnosis around each turn. Many times we could probably allay his apprehension with a well chosen remark.

In addition to treating and consoling a patient, it is now frequently necessary that we become his teacher of pathological chemistry and physiology as well, to explain the whole course of his diagnosis and treatment as we go along. As with most everything else in medicine, these explanations need to be individualized. What calms fears in one patient may cause them in the next.

But if the trend continues, more and more patients are going to desire or demand a detailed and time consuming explanation of what is being done to them and what they are expected to do during hospitalization. As their attending physicians and friends we should do what we can to satisfy these expectations.

The mystery and hush-hush of hospitalization may be a thing of the past. J. H.

—The Record, Broward County Medical Association, August 1956

Because our living comes from the practice of medicine and socialistic leeches are always present to attack it in the "interest of public welfare," Society business has become a twenty-four hour a day proposition for every member.

—Picomeso Mail Bag, Pinellas C.M.S.

CLASSIFIED

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

MEDICAL OFFICE FOR LEASE: New Medical-Dental Arts Building. Air conditioned. Large waiting rooms. Very reasonable lease for the right medical doctors. Write H. W. Tustison, D.D.S., 1000 S. Federal Highway, Fort Lauderdale, Fla.

WANTED: Physician with Florida license. Interest in Physical Medicine and Geriatrics. State qualifications in writing. The Miami-Battle Creek, Miami Springs, Fla.

PHYSICIAN WANTED: Two General Practitioners, Pediatrician, E.E.N.T. (Board Member), and Psychiatrist to associate with a well established medical group in a rapidly growing central Florida East Coast area. Salary Open — depending on experience and training—with eventual partnership. Give complete personal and professional data in first letter. Florida license required. Write P.O. Box 57, Rockledge, Fla.

OFFICE SPACE AVAILABLE: In store building with dentist; accountant, and drug store. Will alter to suit. Highly populated area. No doctor in area. Write to M.A. Cinotti, 3698 Tangerine, St. Petersburg, Fla.

AVAILABLE: In Winter Park Professional building now under construction 3 ground floor suites for specialties on cooperative or rental basis. Centrally located. Particulars on request. Arnold Menk, 333 Park Ave., Winter Park, Fla.

FOR SALE: New 14 bed Nursing Home well equipped also beautiful new residence both in 10 acre orange grove. Nursing home easily adaptable for doctors practice. Shown by appointment. Apply Box 47, San Antonio, Fla.

WANTED: Internist, Pediatrician or General Practitioner to fill vacancy in South Central Florida in association with surgeon. Unusual opportunity to get quickly established without great expense. Write for appointment for interview. Write 69-197, P.O. Box 2411, Jacksonville, Fla.

WANTED: Well established Florida group intends to add additional General Practitioner, Internist, Ophthalmologist-Otolaryngologist and Pediatrician in near future. Write 69-202, P.O. Box 2411, Jacksonville, Fla.

TWO INTERNISTS NEED THIRD: In South Florida, Board eligible, deferred. Write age, training, marital and military status, chronology of business and medical experience, references. Write 69-203, P.O. Box 2411, Jacksonville, Fla.

FOR RENT: Duplex building (just completed for two doctors or doctor and dentist). Sarasota's fastest growing section adjacent to most exclusive subdivision in Sarasota. Ideal for General Practitioner. No doctor in this area. Seven minutes drive to hospital, 10 minutes to downtown and 10 minutes to beaches. Write Archie Edwards, 2030 Oak Terrace, Sarasota, Fla. Telephone RI 6-2843.

GENERAL PRACTITIONER: Excellent opportunity in Orange City. Approximately 6000 population in area not served by a doctor. Finest living conditions in fast growing Central Florida. Write for information. Harry F. Edwards, Box 708, Orange City.

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for prophylaxis and treatment of

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ACHROMYCIN SF

ACHROMYCIN with STRESS FORMULA VITAMINS. Attacks the infection, bolsters the patient's natural defenses, thereby speeds recovery. Especially useful in severe or prolonged illness. Stress formula as suggested by the National Research Council.

SF Capsules, 250 mg.
SF Oral Suspension, 125 mg. per teaspoonful (5 cc.)

For more rapid and complete absorption. Offered only by Lederle!

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[1]Posner, A. C., *et al.;* Further Observations on the Use of Tetracycline Hydrochloride in Prophylaxis and Treatment of Obstetric Infections, *Antibiotics Annual* 1954-55, pp. 594-598.

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BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Paul L. Mahoney, of Jacksonville, announce the birth of a daughter, Leigh Ann, on August 11, 1956.

Dr. and Mrs. James G. Lyerly Jr., of Jacksonville, announce the birth of a daughter, Emily Fairfax, on September 5, 1956.

Marriages

Dr. Herbert A. King, of Daytona Beach, and Miss Carol Filer were married August 28, 1956, in Daytona Beach.

Deaths — Other Doctors

Baeseman, Reuben W.,
Allenhurst, N. J. ..... February 1, 1956
Balofsky, Samuel Lawrence,
Detroit, Mich. ..... August 11, 1956
Burley, Benjamin T., Cohasset, Mass. ..... May 16, 1956
Dees, John H., Miami, Fla. ..... August 24, 1956
Dunn, James M., Long Island, N. Y. ..... April 10, 1956
Jones, Edwin M., Fellsmere, Fla. ..... August 13, 1956
Love, John Robert, Lakeland, Fla. ..... March 22, 1956
Tedesche, Leon G., Miami, Fla. ..... April 29, 1956

Medical Officers Returned

Dr. Paul J. McCloskey, who entered military service on September 11, 1954, was released from active duty on September 10, 1956, with the rank of captain, U. S. Army. His address is 1801½ 22nd Ave., Tampa.

STATE NEWS ITEMS

Drs. Alvan G. Foraker and Sam W. Denham of Jacksonville have received a cancer research grant from the National Cancer Institute of the Department of Health, Education and Welfare. It is to be used in studies which involve chemical and special microscopic examinations of experimental tumors of the ovary and uterus and is a continuation of research done by Drs. Foraker and Denham at Emory University.

Dr. Richard A. Henry of Brooksville has begun a three months course at the Tampa Municipal Hospital in the more advanced anesthesia technics.

Dr. Joseph L. Selden Jr. of Ft. Myers has returned from Chicago where he attended the meetings of the International College of Surgeons.

Dr. Thomas C. Butt of Orlando, president of the Orange County Medical Society, has been appointed chairman of the Doctors' Division of the United Appeal of Orange County.

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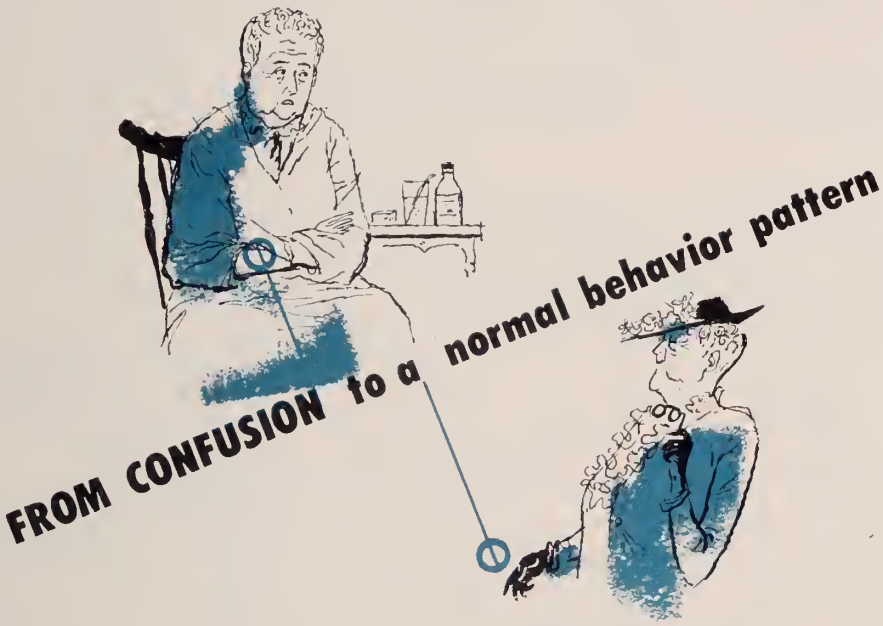

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relieves mental confusion and deterioration, mild memory defects and abnormal behavior patterns.

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REHABILITATION and RELEASE
from public and private psychiatric institutions for the mildly confused and mildly deteriorated aged patients may be accomplished by treatment with the NICOZOL formula. 1-2-3

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in capsule and elixir forms.
Each capsule or ½ teaspoonful of elixir contains:
Pentylenetetrazol —— 100 mg.
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1. *Levy, S.* J.A.M.A. *153:1260, 1953.*
2. *Thompson, Lloyd & Proctor, Rich.* N. C. State, *Dec. 54*
3. *Thompson & Proctor,* Clinical Med *April, 1956*

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Bulk makes the "Regularity" Diet work!

Rough or gentle, bulk for the ordinary "regularity" diet comes from the cellulose of foods plus a liberal fluid intake. Where roughage is needed, foods may be eaten raw or cooked. In the bland diet, fruits can be stewed and vegetables puréed.

These are for bulk—

Fruits and vegetables are high in cellulose. And fruits like oranges and apples, root vegetables like beets and carrots also provide pectin which absorbs even more fluid to form especially smooth, soothing bulk.

Whole grains—and the flour or meal made from them—not only contain cellulose, but provide Vitamin B complex as well.

And lots of liquid to make the cellulose bulky—about 8 to 10 glasses a day. Not all of that has to be water—in fact, some of it might be beer.*

Team them up for appetite appeal—

Boiled beets take on new interest when they're served in a sauce of orange juice combined with a little sugar, cornstarch, and butter.

Apples team nicely with dates. Serve them diced with mayonnaise for salad. Or for dessert, stuff cored apples with dates and bake in orange juice.

Currants, raisins, or fresh cranberries make a tasty surprise in oatmeal muffins.

When your patient learns that these bulk-producing foods can be made appetizing, he's likely to make them a part of his regular diet and in doing so help prevent recurrence of his condition.

United States Brewers Foundation

Beer — America's Beverage of Moderation

*An 8-oz. glass of beer supplies about 1/8 the minimum daily requirement of Niacin as well as smaller amounts of other B Complex vitamins. (Average of American beers)

If you'd like reprints of 12 special diets, please write United States Brewers Foundation, 535 Fifth Avenue, New York 17, N. Y.

Dr. James N. Patterson of Tampa has been elected a district director of the American Association of Blood Banks.

Dr. William Ingram Jr. of Jacksonville was commencement speaker for the class of practical nurses graduated recently from Technical High School in the city.

Dr. Harold T. Lawler of Sarasota has returned from Chicago where he attended a postgraduate course presented by the Department of Cardiovascular Research of the Michael Reese Hospital.

Dr. Leo M. Wachtel Jr. of Jacksonville has been elected to the board of trustees of Bolles School located in the city.

Dr. Daniel B. Langley of Naples discussed poliomyelitis and the effects of the Salk vaccine on present epidemics at a recent meeting of the Naples Exchange Club.

Dr. Turner Z. Cason of Jacksonville has been elected president of the Duval District Heart Association.

Dr. Herbert L. Bryans of Pensacola was one of the principal speakers at the sixth annual convention of the Licensed Practical Nurses Association held recently at Pensacola.

Dr. Gail M. Osterhout of Inverness discussed the plans for establishing a 25 bed hospital in Citrus county at a recent meeting of the Bushnell Kiwanis Club.

Dr. Carl C. Mendoza of Jacksonville, a member of the State Board of Health, has returned from Key West where he conferred with members of the Monroe County Medical Society and other county, city and Navy officials regarding public health facilities and needs.

Dr. Louis M. Orr of Orlando was one of the principal speakers on the program of the First Pan-American Congress of Gerontology held the middle of September in Mexico City. The title of his address was "Aspects of Surgery in the Geriatric Patient."

Dr. Jacob A. Glassman of Miami, Assistant Clinical Professor of Surgery at the University of Miami School of Medicine, was a member of the

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- relieves pain promptly
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Monodral with Mebaral—the "psychovisceral stabilizer"—provides for patients with ulcer and gastro-intestinal spasm an effective barrier against the impact of environmental stimuli . . . controls gastric hypersecretion and hypermotility for three and one half to five hours.*

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Monodral bromide..... 5 mg.
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DOSAGE: 1 or 2 tablets three or four times daily.
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Bottles of 100 tablets.

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*References and clinical trial supplies available on request.

faculty for the postgraduate session presented by the International College of Surgeons at Chicago the latter part of October. Dr. Glassman's subjects were "The Present Status of Thyroid Surgery," and "Gastric Surgery."

Dr. Henry B. Dickens Jr. of Fernandina Beach participated in the program "The Family in the Community" presented recently by the Women of the Church of the First Presbyterian Church of that city. In his address, Dr. Dickens pointed out the close tie between the family and the family physician and stated that it was absolutely necessary for the physician to know something of the background of the patient in order to successfully treat his illness.

Dr. Vincent P. Corso of Miami discussed "Psychosomatic Medicine" before the Miami Community Forum held the middle of September in the First Unitarian Church there.

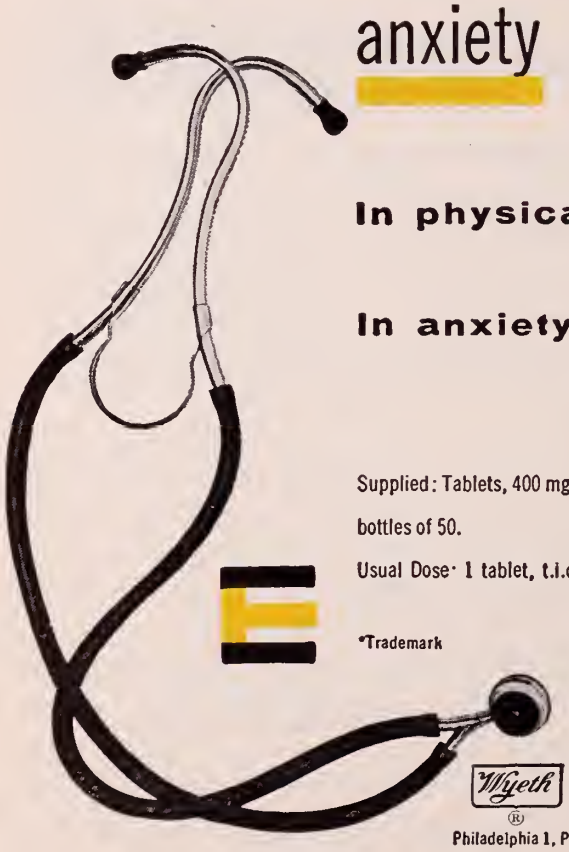
The name of the Duval District Heart Association has been changed to Northeast Florida Heart Association by vote of the organization's Board of Directors. Included in the Association are nine counties.

Dr. Carlos P. Lamar of Miami attended the First Pan American Congress on Gerontology in Mexico City as an official delegate appointed by the dean of the University of Havana Medical School. He was a member of the "Presidium" on Gerontological Nutrition and also presented a paper on "New Concepts on the Elderly Diabetic."

Dr. Lamar also will attend the first meeting of the Latin American Chapter of the World Medical Association as an American observer and as an official delegate of the Latin American Confederation of Gerontology and Geriatrics of which he was elected a director in Mexico City.

The Sarasota and Manatee County Medical Societies and The Manasota Medical Foundation are presenting a Geriatric Seminar December 3-7, 1956, in the Orange Blossom Hotel at Sarasota. Approved for credit by the American Board of General Practice, the Seminar features a panel of prominent physicians from Atlanta: Drs. Hal M. Davison, Harold P. McDonald, A. H. Letton and T. Sterling Claiborne. There is no registration fee. The material to be presented will be general in nature but with primary emphasis on geriatric problems.

anxiety is part of every illness



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In addition to the direct benefit of rapid symptomatic improvement, Achrocidin promptly controls the bacterial component frequently responsible for the development in susceptible individuals of sequelae such as otitis media, sinusitis, adenitis, and bronchitis.

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Phenacetin	120 mg.
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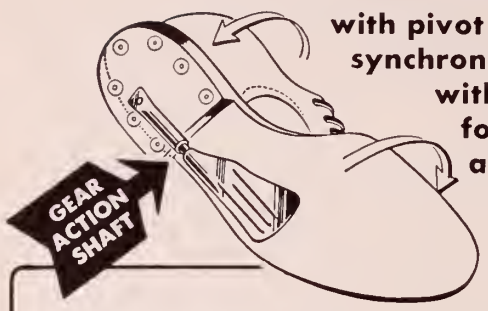

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*Griffith, G. C.; Dimitroff, S. P., and Thorner, M. C.: Ann. Int. Med. 45:7, 1956.

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COMPONENT SOCIETY NOTES

Dade

Dr. Frank G. Dickinson, of Chicago, Director of the Bureau of Medical Economic Research of the American Medical Association, was principal speaker on the program for the October meeting of the Dade County Medical Association. His subject was "M.D.'s and Social Security Retirement Benefits."

Duval

Dr. Clarence M. Sharp, of Jacksonville, was principal speaker at the October meeting of the Duval County Medical Society. The title of his address was "Diseases of the Chest Found by 70 mm. X-ray Examinations of Presumably Well Persons in Duval County."

Dr. Sharp is Director of the Bureau of Preventable Diseases of the Florida State Board of Health.

Hillsborough

Dr. James H. Ferguson, of Miami, Professor of Obstetrics and Gynecology at the University of Miami School of Medicine, was principal speaker at the October meeting of the Hillsborough County Medical Association. The meeting was held in the New Hillsboro Hotel and was preceded by a social hour and dinner. Dr. Ferguson discussed "Fertility Problems of the General Practitioner."

Lake

Dr. Frank G. Dickinson, Director of the Bureau of Medical Economic Research of the American Medical Association, addressed the Lake County Medical Society at its October meeting. The title of his address was "Why the Doctor Should Not Be Taken In by Social Security." Invited guests for the meeting were members of the Orange, Seminole and Marion County Medical Societies.

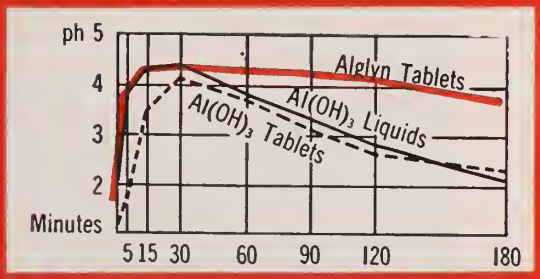
Dr. Lawton F. Douglass, of Umatilla, served as program chairman for October.

Pinellas

The annual meeting of the Pinellas County Medical Society was held at the Lakewood Country Club in St. Petersburg on October 1. The business session was preceded by dinner served early in the evening.

Dr. Percy H. Guinand, of Clearwater, succeeded Dr. Daniel F. H. Murphey as president of the Society at this meeting.

Announcing Revision of N.N.R. Monograph for



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> "Dihydroxy aluminum aminoacetate . . . shares the properties of the aluminum hydroxide gel preparations. *In vitro* studies indicate that the buffering action of dihydroxy aluminum aminoacetate in tablet form is comparable to that of the liquid preparations of aluminum hydroxide gel when compared on the basis of equivalent aluminum content."

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Reprint of recent *in vivo* studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:536, 1949.

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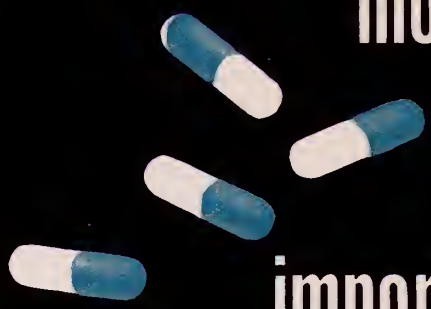

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DOSAGE: *for adults—two capsules q.i.d.; for children under 100 lbs.—dosage in proportion to weight (e.g. one capsule q.i.d. for a child weighing 50 lbs.).*

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—for these clinically important infections: tonsillitis; pharyngitis; pneumonia; otitis media; cervical lymphadenitis; streptococcal sore throat; infected tooth sockets; Vincent's infection; acne and superficial skin infections; impetigo; boils, furuncles and carbuncles; lung abscess; bronchitis; mastitis; osteomyelitis; wound infections; postoperative wound infections and infected lacerations; staphylococcal enteritis, staphylococcal diarrhea of the newborn; peritonitis (caused by susceptible organisms); pelvic inflammatory disease; gonorrhea; gonococcal arthritis; urethritis; scarlet fever; erysipelas.

SUPPLIED: *Blue and white capsules of* 'Cathocillin' *—each containing 125 mg. of* 'Cathomycin' *(as Sodium Novobiocin, Merck) and 75 mg. (125,000 units) Potassium Penicillin G; bottles of 16.*

In one prescription the one antibiotic product most likely to be effective

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relaxes both the body and the mind

well suited for prolonged therapy

- well tolerated, nonaddictive, essentially nontoxic
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Indications: **anxiety and tension states, muscle spasm.**

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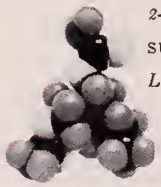
SUPPLIED: *400 mg. scored tablets. Usual dose: 1 or 2 tablets t.i.d.*

Literature and Samples Available on Request



THE MILTOWN MOLECULE

CM 3706R

Sodium Restriction

A. Indications

1. Congestive heart failure
2. Hypertension
3. Cirrhosis
4. Pregnancy edema
5. Obesity

B. Management

1. Salt Free Diet
2. Salt Substitutes

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New improved formula - now the best tasting. Used like table salt.

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METRETON *tablets*

METICORTEN (PREDNISONE) PLUS CHLOR-TRIMETON WITH ASCORBIC ACID

For prompt and effective relief, especially in many resistant allergic disorders, METRET affords the benefits of two established agents with unexcelled anti-inflammatory, an allergic and antipruritic effectiveness. *supported by essential vitamin C*—for str support and for postulated effect on prolonging steroid action *no better corticostero* —original brand of prednisone...minimal electrolyte effects—METICORTEN *no better an histamine*—unexcelled in potency and freedom from side effects—CHLOR-TRIMET effective against hay fever, pollen asthma, perennial rhinitis, acute and chronic urticar angioneurotic edema, drug reactions, inflammatory and allergic eye disorders, pruri and contact dermatoses.

formula: Each tablet of METRETON provides 2.5 mg. of METICORTEN (prednisone), 2 mg. of CHLOR-TRIME maleate (chlorprophenpyridamine maleate), and 75 mg. ascorbic acid.

supplied: METRETON Tablets, bottles of 30 and 100.

frontal attack

allergies

new

METRETON *nasal spray*

METICORTELONE (PREDNISOLONE) PLUS CHLOR-TRIMETON

quickly clears nasal passages • avoids rebound engorgement and sympathomimetic side effects • safe even for cardiacs, hypertensives, children, pregnant patients •

Composition: Contains 2 mg. (0.2%) METICORTELONE acetate (prednisolone acetate) and 3 mg. (0.3%) of CHLOR-TRIMETON gluconate (chlorprophenpyridamine gluconate) in each cc.

Packaging: 15 cc. plastic "squeeze" bottle, box of 1.

METRETON,* brand of corticoid-antibistamine compound; METICORTEN,* brand of prednisone; METICORTELONE,® brand of prednisolone; CHLOR-TRIMETON,® brand of chlorprophenpyridamine preparations. *T.M.

MT-J-876

Schering

Erythrocin in treating tonsillitis and otitis externa*

2/22/56 DISCHARGE SUMMARY

Patient, white male, age 4, entered the clinic on 2/13/56, with a history of yellow discharge from the right ear, a fever, and sore throat of two days duration.

Temperature orally was 100°, pharynx infected, tonsils inflamed, crusted purulent material seen in right ear canal; tympanic membrane normal. Diagnosis -- tonsillitis and otitis externa.

Culture revealed Staphylococcus aureus, coagulase positive, resistant to penicillin and sensitive to erythromycin.

ERYTHROCIN (erythromycin) was started in doses of 25 mgm/kg -- 400 mgm in 4 equally divided doses.

After 24 hours of therapy, patient was afebrile and comfortable. T = 99.6. Throat slightly infected. Secretions in ear canal were dry and both tympanic membranes were normal.

Culture on 2/15 showed no coagulase positive staphylococci or other pathogens. On 2/22, follow-up exam showed him to be completely asymptomatic and free of unusual physical findings. The drug was stopped at this time.

Final Diagnosis: tonsillitis and otitis externa due to Staphylococcus aureus.

Result: complete clinical bacteriologic cure after 9 days with ERYTHROCIN therapy.

*Communication to Abbott Laboratories

"clinical response good or excellent"

In one recent study, 18 patients with acute follicular tonsillitis and septic sore thro were given erythromycin. Infecting organism was *Str. pyogenes*. The investigato stated, "*In all 18, the clinical response could be regarded as either good or excellent.*"[1]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when your prescription reads *Filmtab* ERYTHROCIN Stearate.

"toxicity lower in erythromycin-treated patients"

After a study of 208 patients treated with erythromycin (78), procaine penicillin (78) and a placebo (52), the investigator stated: ". . . *the incidence o toxicity* (compared to procaine penicillin) *was significantly lower in the erythromycin-treated patients.*"[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four ye there's not a single report of a severe or fatal reaction attributable to erythromycin. Also, allergic reactions rarely occur. *Filmtab* ERYTHROCIN Stearat (100 and 250 mg.), is available in bottles of 25 and 100, at all pharmacies.

Abbo

® Filmtab—Film sealed tablets, Abbott, applied for.

1. Herrell, W. E., Erythromycin, Antib Monographs, No. 1, p. 29, New York, ical Encyclopedia, Inc., 1955.
Idem p. 30.

filmtab®

Erythrocin® STEARA

PROVEN
PAIN CONTROL
with safety

GRADATIONS OF ANALGESIA

'TABLOID' 'EMPIRIN' COMPOUND®
Acetophenetidin gr. 2½, Acetylsalicylic Acid gr. 3½, Caffeine gr. ½

'TABLOID' 'EMPIRIN' COMPOUND
with CODEINE PHOSPHATE gr. ⅛, No. 1 (N)

'TABLOID' 'EMPIRIN' COMPOUND
with CODEINE PHOSPHATE gr. ¼, No. 2 (N)

'TABLOID' 'EMPIRIN' COMPOUND
with CODEINE PHOSPHATE gr. ½, No. 3 (N)

'TABLOID' 'EMPIRIN' COMPOUND
with CODEINE PHOSPHATE gr. 1, No. 4 (N)

(N) subject to Federal Narcotic Law

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Tuckahoe, N. Y.

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TO THE
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Mrs. John R. Browning, Yearbook.....*Jacksonville*

National Auxiliary Program Expanded

The Woman's Auxiliary to the American Medical Association has now sent out the program and project material for 1956-57. Mrs. Robert Flanders, president, has chosen as the theme for this year "Health is our Greatest Heritage." Thus the programs reflect further and further interest in promotion of good health.

Generally speaking, some of the suggestions and ideas for program and project sent out by the national auxiliary this year are as follows:

The American Medical Education Foundation will follow two major procedures — ways and means to augment the financing of our American medical schools on a voluntary plan of giving funds from our members as individuals or our auxiliaries, and, education of the lay public as to the need for voluntary financing of our medical schools without government intervention.

The Legislative Committee has proposed that we limit our support of legislative matters to certain specified bills again this year but that we be informed on all national health bills. Study

groups within auxiliaries are suggested in order to have informed members and in order to form a nucleus of action by these members. It is to be remembered that as auxiliaries we neither support nor endorse candidates but as individuals, we have an obligation to work for both candidates and legislation which we approve.

The membership will work under three phases this year to be known as the three R's. These three R's could well be used by medical associations as well as the auxiliaries and are: RETAIN the members you have, RETRIEVE the members you have lost, and RECRUIT the new members as they come into your community.

Generally, the Program Committee has asked that our programs be based on Understanding our Health Heritage, Building our Future Health Heritage, Preserving our Health Heritage, Defending our Health Heritage and Interpreting our Health Heritage. This is more than a big order for one year and one that we can well take to work upon for years to come. Tying public relations into this program means our active participation in this type of program in our own communities. We are asked to remember that all our programs and projects are a part of our public relations and that through cooperation with others in our communities and education for others we are doing a job of which we can be proud.

Todays Health is suggesting a three R program, also. Their three R's are different from those of membership because theirs have to do with augmenting and consolidating the circulation of the only authentic health magazine on the American market. Based on the fact that the best place in the world for the laity to find *Todays Health* is in the doctor's office waiting room, the three R's are RECEPTION ROOM READERSHIP. This entails getting subscriptions from the doctors for *Todays Health* to be in their waiting rooms, and, the encouragement of doctors' secretaries or nurses to encourage people to read it — having it available where the patient can see it — not stuck off in a corner.

The Bulletin, which is the workbook of the National Auxiliary and is published quarterly, will be emphasized this year for the orientation of all members, not just to be used by officers and chairmen of committees. All of us know that an informed membership is an active and interested one giving impetus and importance to all that we do.

(Continued on Page 513)

PROVEN PAIN CONTROL
with sedation

GRADATIONS OF ANALGESIA
with light sedation

'EMPIRAL'®

Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Acetylsalicylic Acid	gr. 3½

'CODEMPIRAL'® No. 2(N)

Codeine Phosphate	gr. ¼
Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Acetylsalicylic Acid	gr. 3½

'CODEMPIRAL'® No. 3(N)

Codeine Phosphate	gr. ½
Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Acetylsalicylic Acid	gr. 3½

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to quiet the cough

and calm the patient . . .

Expectorant action
Antihistaminic action
Sedative action
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EXPECTORANT

Promethazine Expectorant with Codeine Plain (without Codeine)

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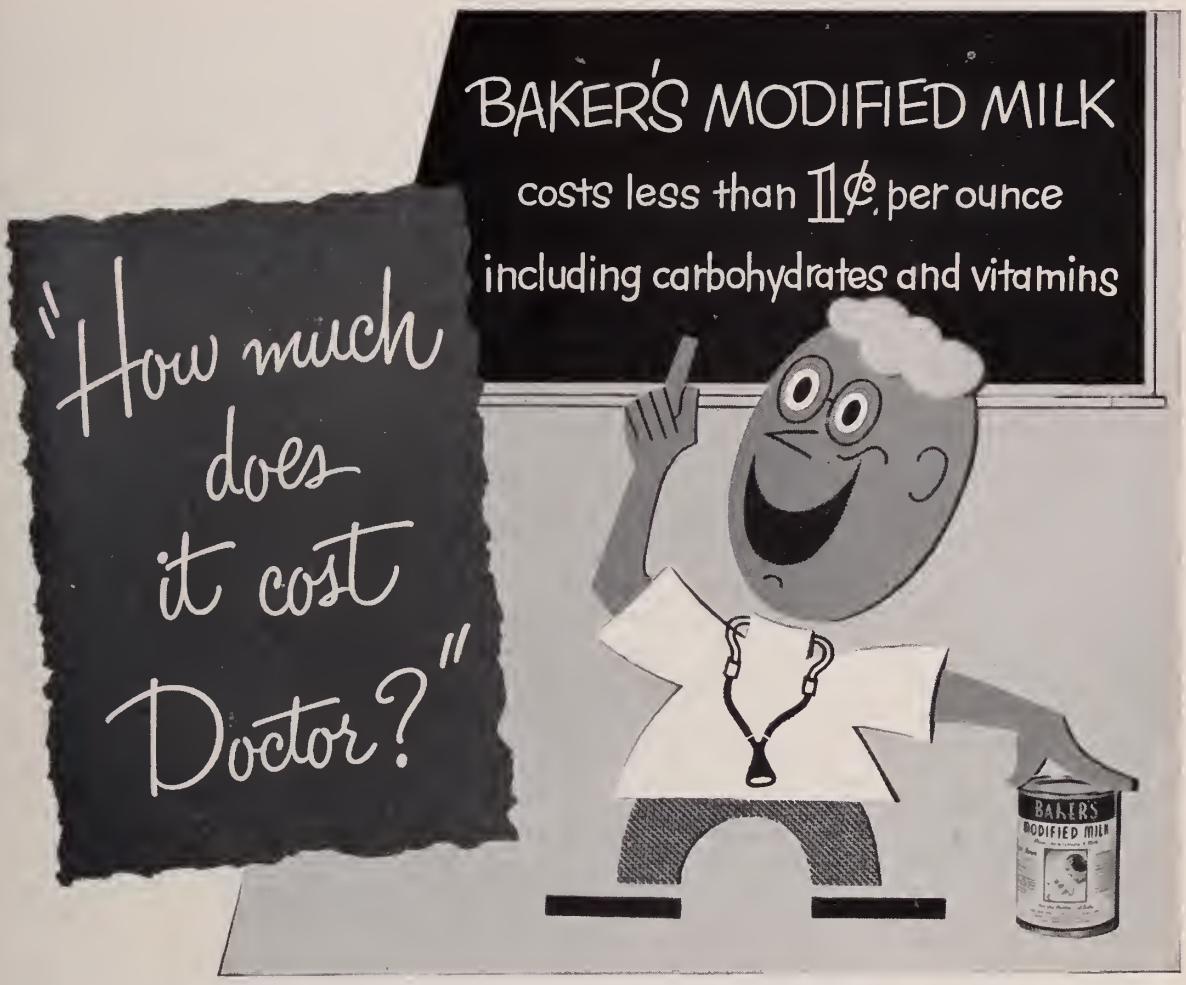

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Baker's is a complete food containing added carbohydrate, and adequate amounts of all known essential vitamins and minerals. Because Baker's is sold at an extremely low price, one ounce of formula costs less than a penny—about $1.50 per week for most infants.

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*Made exclusively from Grade A Milk (U.S. Public Health Service Milk Code)

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Typical Sanka Booth At Medical Conventions All Over The Country

You said, "THIS IS REAL COFFEE!"

and your patients will agree!

***"Real* coffee**—delicious coffee!" Such was your enthusiastic comment at medical conventions—when you tasted Instant Sanka at the Instant Sanka booth.

And, Doctor, you couldn't be more right. Since only the caffein has been removed from Instant Sanka Coffee, all the pure coffee goodness is there for you to enjoy.

Why not share the good news with your patients? If they're sensitive to caffein—if they're sensitive to good coffee flavor—then Instant Sanka Coffee is for them!

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All pure coffee... 97% caffein-free

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How to win friends ...

The Best Tasting
Aspirin you can prescribe.

The Flavor Remains Stable
down to the last tablet.

25¢ Bottle of 48 tablets (1¼ grs. each).

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for the majority of diabetics

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Brings
new certainty to
antibiotic therapy
particularly for the
90% of patients
treated in home
or office

new
Sigmamycin*
OLEANDOMYCIN TETRACYCLINE

*TRADEMARK

a new maximum
in therapeutic
effectiveness

a new maximum
in protection
against
resistance

a new maximum
in safety and
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multi-spectrum
synergistically
strengthened...

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a new certainty

in antibiotic therapy, particularly for the 90% of patients treated at home and in the office

Superior control of infectious diseases through superior control of the changing microbial population is now available in a new formulation of tetracycline, outstanding broad-spectrum antibiotic, with oleandomycin, Pfizer-discovered new antimicrobial agent which controls resistant strains. The synergistic combination now brings to antibiotic therapy: (1) a new fuller antimicrobial spectrum which includes even "resistant" staphylococci; (2) new superior protection against emergence of new resistant strains; (3) new superior safety and toleration. *TRADEMARK

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of infectious disease through
superior control of the
changing microbial population

new
Sigmamycin*

OLEANDOMYCIN TETRACYCLINE

A synergistically strengthened multi-spectrum antibiotic

Sigmamycin is a new antibiotic formulation providing: (1) the unsurpassed broad-spectrum activity of tetracycline, the outstanding broad-spectrum antibiotic discovered and identified by Pfizer; (2) the action of oleandomycin, the new antimicrobial agent which combats those strains, particularly among staphylococci, now resistant to tetracycline and other antibiotics.

Sigmamycin embodies a new concept in the use of antibiotics, for with this new synergistically active preparation, the development of refractory pathogens and their emergence as important sources of superinfection are more fully controlled.

New superior safety and toleration— Sigmamycin brings to antibiotic therapy new superior safety, new unexcelled toleration because: (1) tetracycline, an outstandingly well-tolerated antibiotic, is formulated with oleandomycin, also known to be remarkably free of adverse reactions; (2) the synergism between oleandomycin and tetracycline enhances antimicrobial potency.

Dosage: 1 to 2 capsules q.i.d.

Supplied: Capsules, 250 mg. (oleandomycin 83 mg., tetracycline 167 mg.) Bottles of 16 and 100.

*TRADEMARK

Pfizer

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Meat...

Good Nutrition and Endocrine Functioning

Maintenance of homeostasis attuned to health devolves upon good nutrition and normal functioning of the enzyme and endocrine systems.[1,2,3] Conversely, by impairing vital activities of the endocrines, poor nutrition can seriously disturb production of hormones needed to regulate metabolic processes.

Intense and prolonged deficiency in essential nutrients and food energy depresses pituitary, gonadal, and other endocrine activity, leading to subnormal physiologic states. Clinical studies exposing male volunteer subjects to a semistarvation diet produced symptoms resembling those of various endocrine dysfunctions.[4] Since the pituitary and other hormones are protein in nature, it appears logical to assume that protein nutrition plays an important part in their synthesis.[5]

Meat, by supplying valuable amounts of high quality protein, B vitamins, essential minerals, and fat containing unsaturated fatty acids, contributes importantly to any role that good nutrition may play in the maintenance of the endocrines, their functioning, and the production of hormones.

---

1. Ralli, E. P., and Dumm, M. E.: The Hormonal Control of Metabolism, in Wohl, M. G.: Modern Nutrition in Health and Disease, Philadelphia, Lea and Febiger, 1955, pp. 57-74.
2. McHenry, E. W.: Nutrition and Endocrine Function, Borden's Review of Nutrition Research, *16*:17 (Mar.-Apr.) 1955.
3. Ershoff, B. H.: Conditioning Factors in Nutritional Disease, Physiol. Rev. *28*:107 (Jan.) 1948.
4. Keys, A.; Brozek, J.; Henschel, A.; Mickelsen, O., and Taylor, H. L.: The Biology of Human Starvation, Minneapolis, University of Minnesota Press, 1950.
5. Samuels, L. T.: Progress in Clinical Endocrinology, New York, Grune and Stratton, 1950, p. 509.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago . . . Members Throughout the United States

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as a potent, specific anti-arthritic

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BUTAZOLIDIN®

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potent, specific anti-arthritic

Based on an impressive background of achievement attained over a period of four years involving both long-term and short-term therapy in all the major forms of arthritis, BUTAZOLIDIN is recognized as one of the most effective anti-arthritic agents currently available.

relieves pain

improves function

resolves inflammation

BUTAZOLIDIN being a potent therapeutic agent, physicians unfamiliar with its use are urged to send for literature before prescribing it.

GEIGY

GEIGY PHARMACEUTICALS, Division of Geigy Chemical Corporation, New York 13, N. Y.

72356

(Continued from page 501)

Preparation for disaster of flood, fire, hurricane and storm are the emphasis in Civil Defense as well as preparation for attack by an enemy, for it is more apparent every day that being prepared for attack by an enemy also prepares us for other major disasters that might happen to us. Recruiting of nurses from our members or laboratory technicians for emergency hospitals will be another emphasis.

The program in mental health from the past year will be carried on with special emphasis to education in the schools and problems of the emotionally disturbed or ill child. It is also suggested that further work can be done in the high schools to interest students in entering one of the fields associated with mental health since there is such a dire need for workers in this field. Volunteer service for auxiliary members is again stressed.

The nurse recruitment program was changed to Recruitment Program at the Board of Directors meeting following the national auxiliary convention in Chicago last June. This was done because there is such need for recruitment of students for laboratory technicians, medical social workers, various types of therapists, et cetera. The major emphasis of this committee, however, will remain on nurse recruitment but with more interest shown in other allied professional needs also. A new committee added by the Board of Directors following the national auxiliary convention in Chicago last June was a Committee on Safety. Mrs. Leo J. Schaeffer, president of the Woman's Auxiliary to the American Medical Association in 1953, made the statement that we should be as much or more interested in keeping our population healthy and safe as we are in curing those who are ill. This committee is a result of our auxiliary realizing our obligation to keep our population healthy and safe.

New committees usually start fairly small and grow in the work they do — such is not the case with our national auxiliary Safety Committee — their program starts with make yourself safety conscious, your family safety conscious and your nation safety conscious. Particularly suggested for auxiliaries this year are: use of good films such as "Home Homicide" at auxiliary meetings, encouragement of courses in driver training education in schools, participation in National Safety Week, and since automobile manufacturers make cars to sell, keeping in mind the woman's view-

Malpractice Prophylaxis

With us
a doctor's involvement
in malpractice charges
are as confidential
as his own relations with his
patient

Specialized Service
makes our doctor safer

THE
MEDICAL PROTECTIVE COMPANY
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"The mercurial diuretics have the justified reputation of being the most powerful and consistently effective of all diuretic drugs."*

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*Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 2, New York, The Macmillan Company, 1955, p. 847.

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EVERY WOMAN

WHO SUFFERS

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MENOPAUSE

DESERVES

"PREMARIN"®

widely used

natural, oral

estrogen

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point, auxiliary members should let the manufacturers know that we want cars with all safety features.

From this program it can be seen that our problem in Florida auxiliaries will not be finding something to do but rather finding time to do it all. Our national auxiliary offers a wealth of suggestions for programs and projects, ours is the job of taking up the program and doing it. Watch us, for at the end of the year you doctors will be amazed at what your wives have accomplished.

Mrs. Richard F. Stover.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Addams, Horace W., Orlando
Anderson, Donald H., Panama City
Mathews, William H., Jacksonville
Mirow, Richard R., Miami
Novell, Howard A., Miami
Pfeifer, Robert H., Fort Lauderdale
Russell, Albert B. Jr., Ft. Walton Beach
Shashy, Samuel A. M., Ocala

BOOKS RECEIVED

The Exceptional Child Faces Adulthood. Proceedings of the 1955 Spring Conference of the Child Research Clinic of The Woods Schools. Pp. 114.

This pamphlet is a report of the conference held last year by The Woods School, a nonprofit residential school for exceptional children in Langhorne, Pa., in collaboration with the Department of Special Education, Teachers College, Columbia University, and the School of Education, City College, New York. Dr. Edward L. Johnstone, the president of The Woods Schools, states that this is the fourth of a special series of conferences dealing with the problems of exceptional children from birth to adulthood.

Authorities in this field discuss such subjects as adjusting the exceptional child to adult life, problems of postadolescence, changing attitudes toward the mentally handicapped, problems of management incident to increasing age, and occupational adjustment. Their addresses are published in full. A section of the pamphlet also is devoted to a panel discussion on social adjustment of the exceptional child from the viewpoint of a parent, psychologist, educator, residential school, sheltered workshop and social service agency.

Single copies are available without charge to parents, psychologists, physicians, educators, sociologists, and members of organizations with a personal and professional interest in the problems of the exceptional child. Additional copies, either singly or in quantity, can be obtained at nominal cost by writing to the Child Research Clinic of The Woods Schools, Langhorne, Pa.

(Reviews of additional Books Received may be found on page 520)

Journal Report:

Hypertensive symptoms relieved in 96% of patients

"Comparison of pentolinium [ANSOLYSEN] with other preparations in 25 patients with severe essential hypertension, for whom all other methods of management had failed, showed that pentolinium is the most effective of available agents in reducing dangerously high blood pressure to the desired levels, and in modifying some of the complications of hypertension, as cardiac decompensation, cardiomegaly and retinopathy. . . .

"In 96 per cent (24 patients) clinical symptoms were relieved and the blood pressure maintained at comfortable levels. . . ."[1]

ANSOLYSEN®

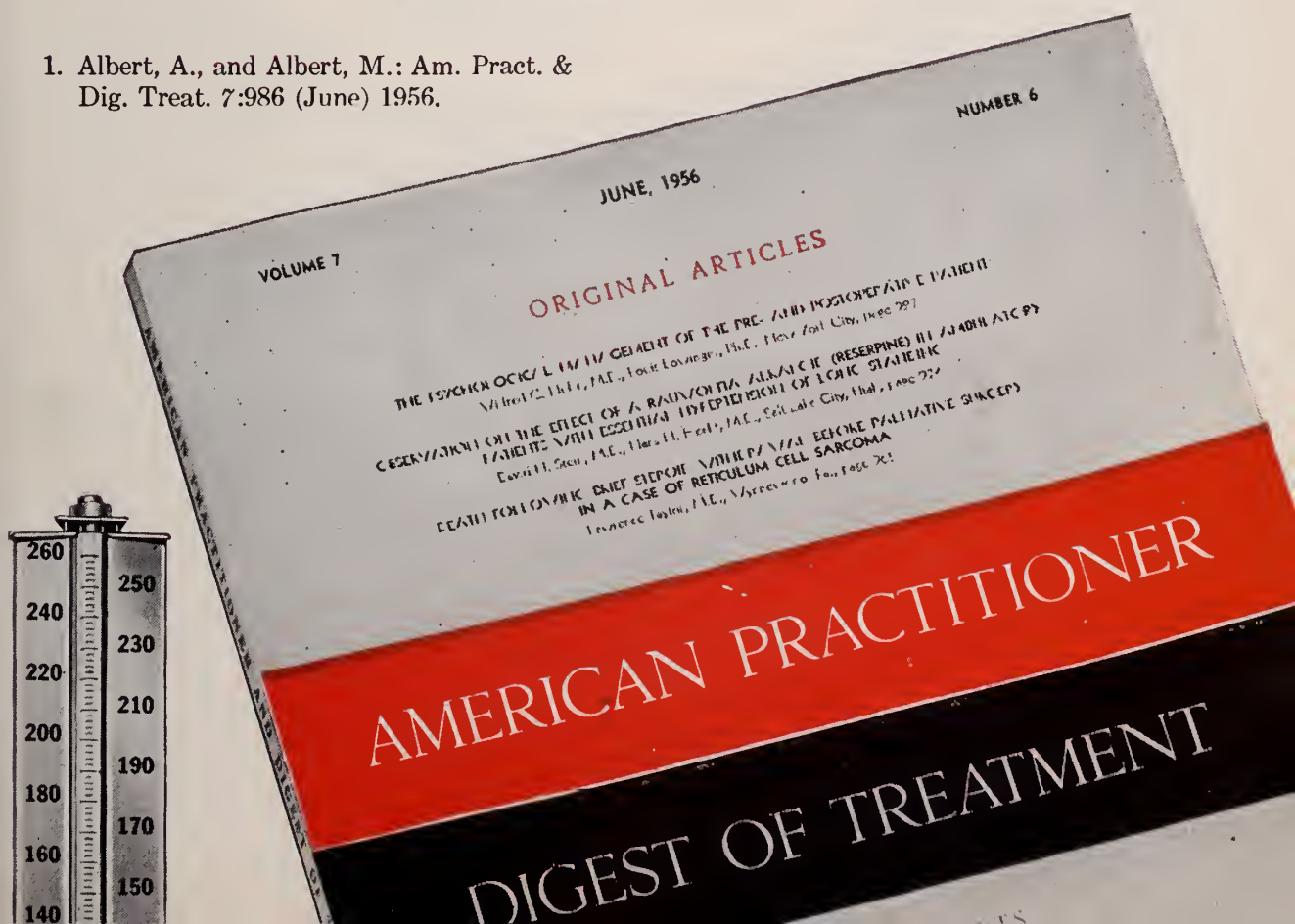
TARTRATE

Pentolinium Tartrate

Lowers Blood Pressure

Wyeth®
Philadelphia 1, Pa.

1. Albert, A., and Albert, M.: Am. Pract. & Dig. Treat. 7:986 (June) 1956.



highly successful . .

- faster relief of pain, photophobia
- better control of inflammation, edema, allergy
- effective against common eye pathogens
- extremely well tolerated

now available

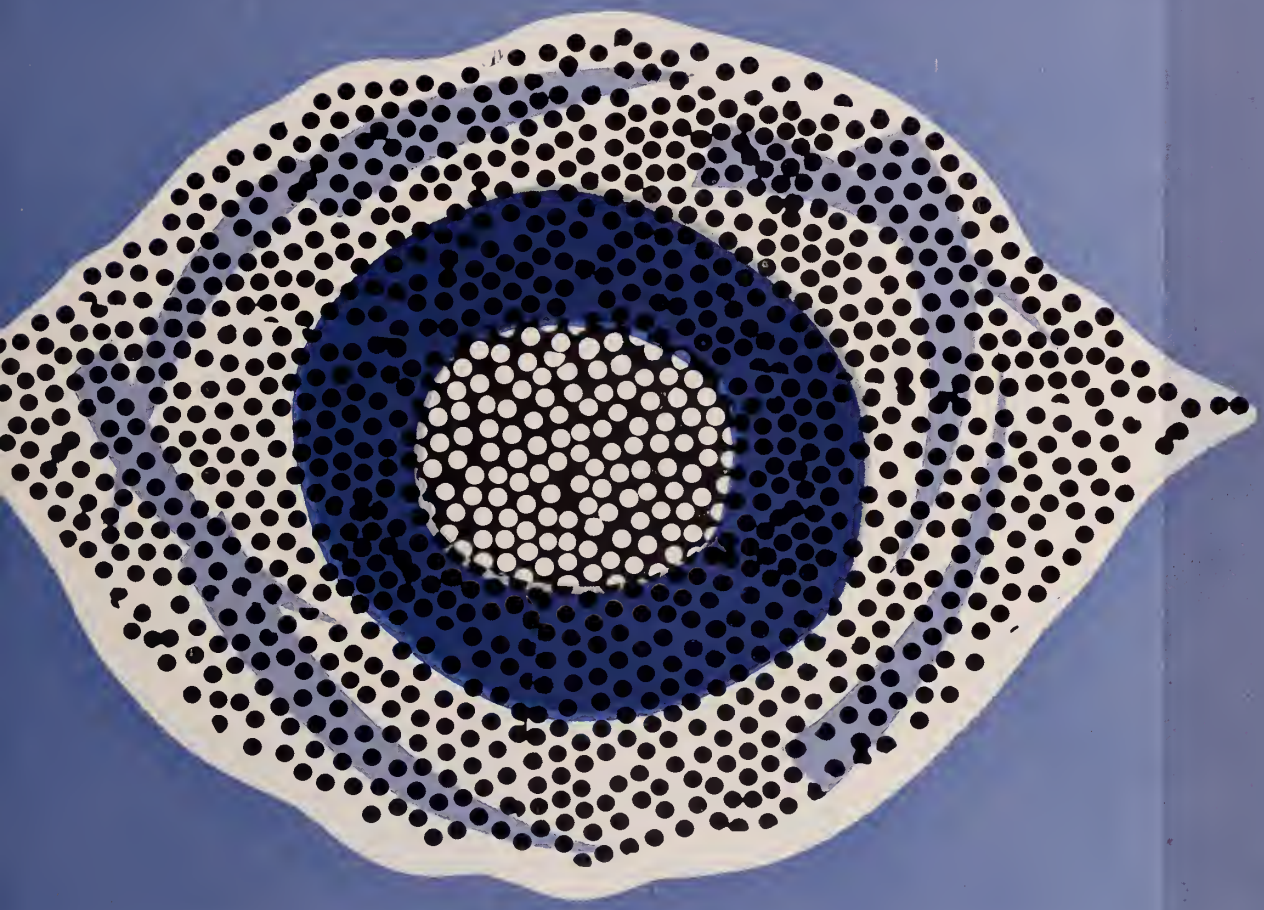
for inflammatory, allergic, infectious or traumatic eye conditions amenable to topical therapy—rapid, potent, topical Meti-steroid and anti-infective action

supplied: METIMYD Ophthalmic Suspension-*Sterile*: prednisolone acetate (METICORTELONE Acetate) 5 mg. per cc. (0.5%) suspended in an isotonic buffered and preserved solution of sulfacetamide sodium 100 mg. per cc. (10%), 5 cc. dropper bottle. METIMYD Ointment with Neomycin: each gram contains 5 mg. prednisolone acetate (METICORTELONE Acetate), 100 mg. sulfacetamide sodium and 2.5 mg. neomycin sulfate (equivalent to 1.75 mg. neomycin base); ⅛ oz. tube, boxes of 1 and 12.

METIMYD,* brand of prednisolone acetate and sulfacetamide sodium.
METICORTELONE,® brand of prednisolone.
*T.M.

MM-J-656

. in topical eye therapy



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(prednisolone acetate and sulfacetamide sodium with neomycin sulfate)

Ointment with Neomycin

antibacterial • antiallergic • anti-inflammatory

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And that *can* be serious — especially if an emergency calls for the use of some "out-of-order" equipment. The best thing to do is to call the Medical Supply Man the minute something goes wrong. He'll put stubborn equipment back in good order in jig time.

In fact, it's a good idea to call the Medical Supply Man anytime you need help. Ordinarily, we carry more than 15,000 individual items in stock at all times and do our very best to furnish you with the supplies and equipment you need — fast!

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Cortef* *tablets*

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Preventive Medicine in World War II. Volume III. Personal Health Measures and Immunization. Editor in Chief, Colonel John Boyd Coates Jr., MC; Editor for Preventive Medicine, Ebbe Curtis Hoff, Ph.D., M.D. Pp. 394. Washington, D. C., Office of the Surgeon General, Department of the Army, 1955.

This volume admirably discusses in proper perspective the major problems encountered and the measures taken by the Medical Department of the United States Army to safeguard the personal health of all Army personnel during the period of World War II. The results form an excellent record of which the nation can be proud, and supply a pattern which should be carefully studied by those who plan the health program of future military forces.

As stated in the preface, grouped within this volume are the accounts of the policies and practices concerned with the various direct personal aspects of preventive medicine as it was applied for the Army during the war period. It is hoped that this concentration of these highly personalized procedures — ranging from personnel selection through nutrition and clothing to the stimulation of specific individual immunity through immunization — emphasizes that preventive medicine is more than the sanitation of the environment and that the prevention of the disease is more to be desired than the nice description of the epidemic and its control. This volume will serve a useful purpose if those who need to learn will read it and if those who read are willing to benefit from the experiences, mistakes, and repetitive efforts of the past.

Therapy of Fungus Diseases. Edited by Thomas H. Sternberg, M.D., and Victor D. Newcomber, M.D. Pp. 337. Price, $7.50. Boston, Little, Brown and Company, 1955.

The symposium reported in this volume was organized for the purpose of stimulating an exchange of ideas on both a national and an international level concerning the therapy of fungus infections. More than 200 leading scientists, representing 24 states and 8 foreign countries, participated in this meeting, presenting the results of their most recent research as well as assessments of many clinical and laboratory aspects of both superficial and deep fungus diseases. Made possible by the financial assistance of the Squibb Institute for Medical Research, this symposium was held under the auspices of the Division of Dermatology, Department of Medicine, School of Medicine and Medical Extension, University Extension, University of California at Los Angeles.

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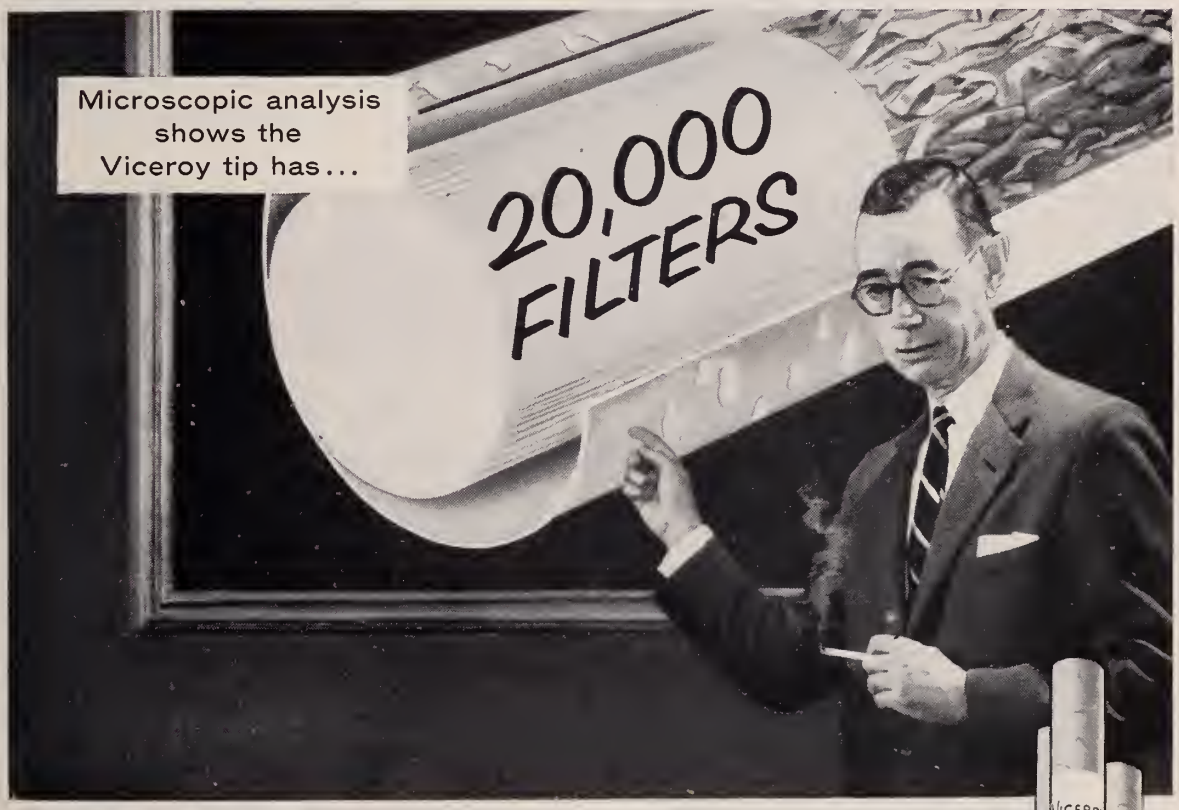

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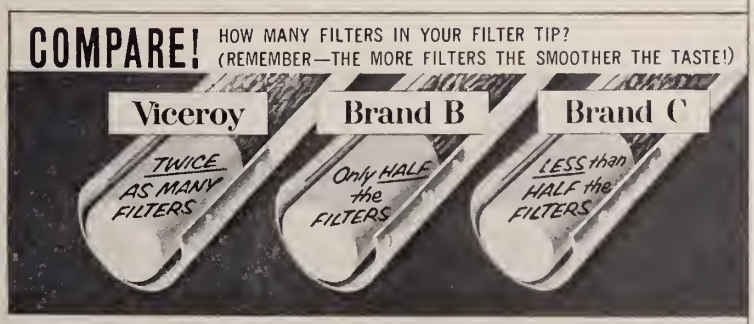

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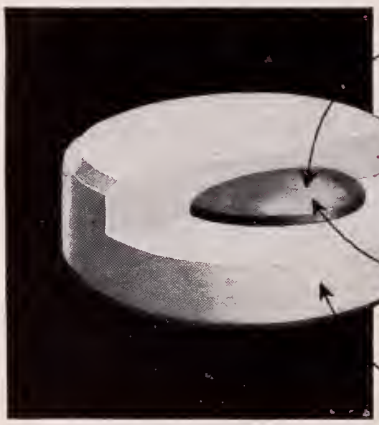

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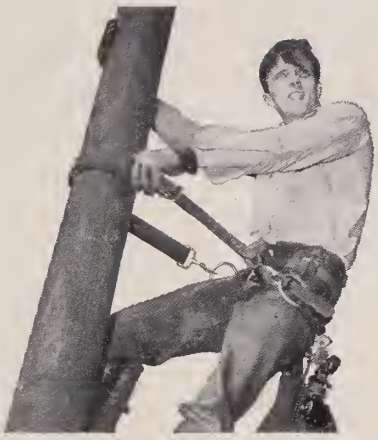

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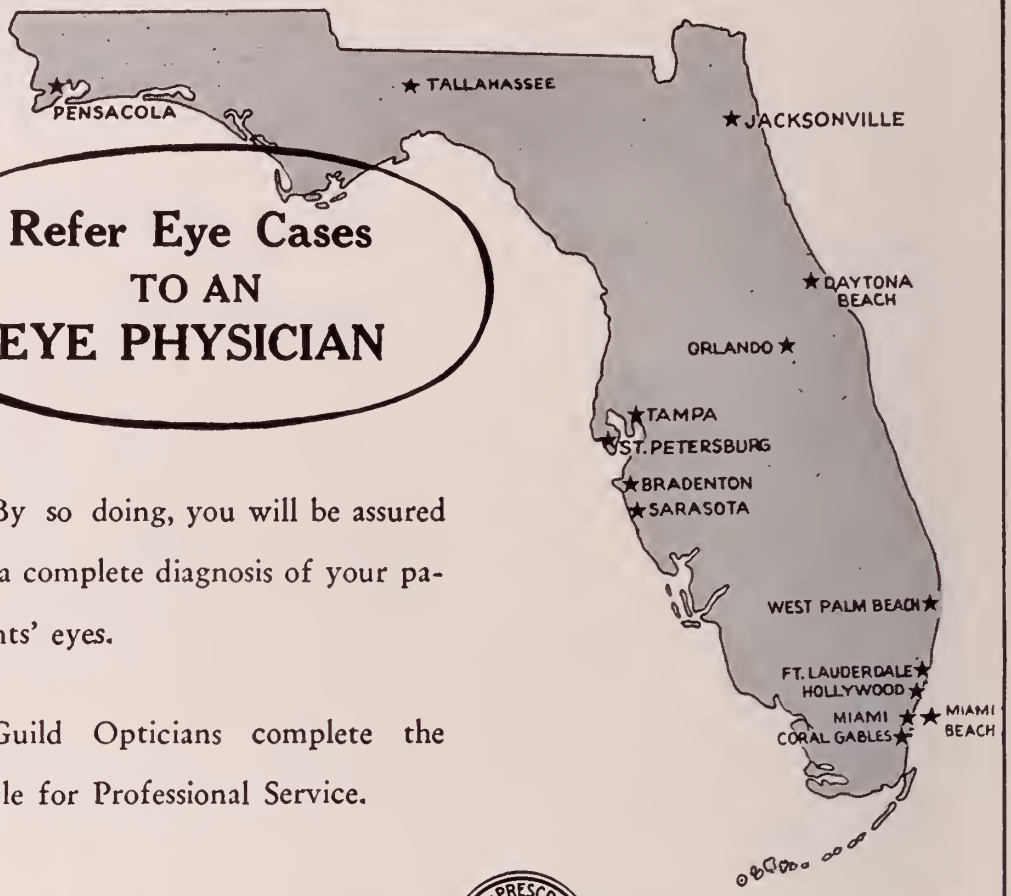

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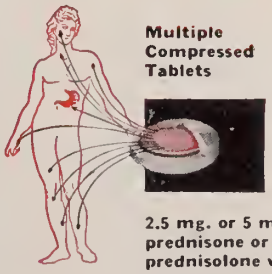

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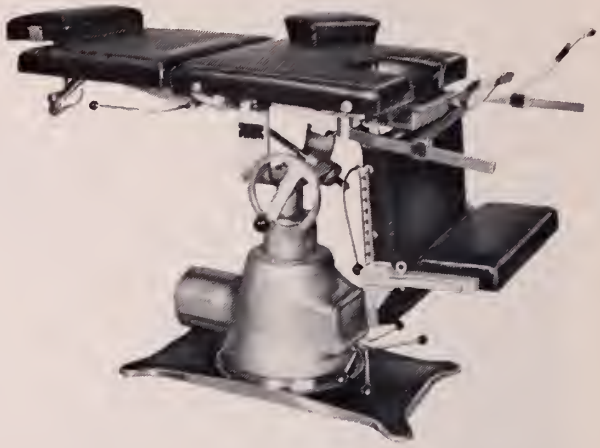

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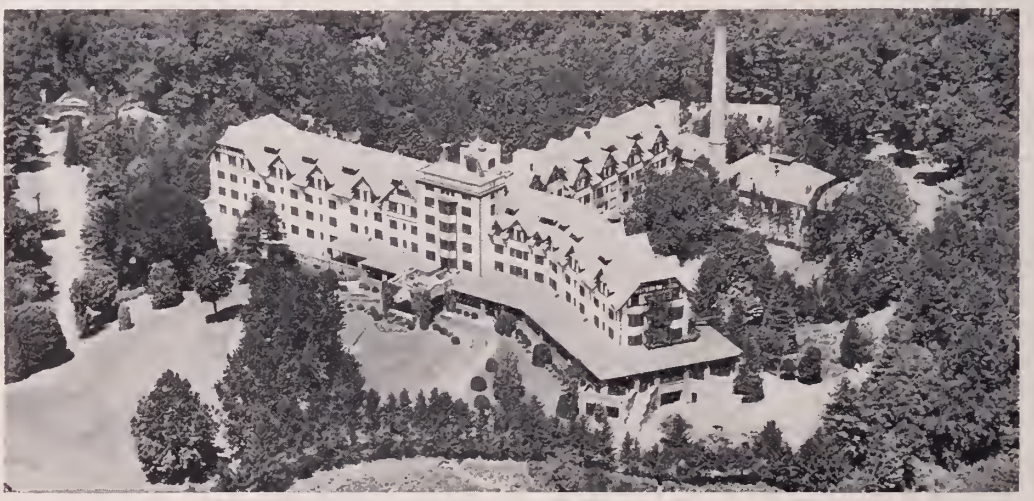

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armaceutical Assoc., State	Wesley D. Owens, Jacksonville	Mr. R. Q. Richards, Ft. Myers	Miami Beach, May 19-22, '57
blic Health Association	Lorenzo L. Parks, Jacksonville	N. J. Schneider, Ph.D., Jax	Clearwater, Oct. 18-20, '56
ideau Society	Simon D. Doff, Jacksonville	Kip G. Kelso, Vero Beach	
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ican Medical Association	Dwight H. Murray, Napa, Calif.	Geo. F. Lull, Chicago	New York, June, 1957
M.A. Clinical Session			Seattle, Nov. 27-30, '56
ern Medical Association	W. Ray McKenzie, Balti., Md.	Mr. V. O. Foster, Birmingham	Washington, Nov. 12-15, '56
ma Medical Association	F. L. Chenault, Decatur	Douglas L. Cannon, Montgomery	
gia, Medical Assn. of	Hal M. Davison, Atlanta	David Henry Poer, Atlanta	Savannah, Apr. 28-May 1, '57
Hospital Conference	Mr. D. O. McClusky Jr., Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	
eastern Allergy Assn.	Ben Miller, Columbia, S. C.	Kath. B. MacInnis, Columbia, S.C.	Charlotte, N. C., Oct. 5-6, '56
eastern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	
eastern Surgical Congress	Donald S. Daniel, Richmond	B. T. Beasley, Atlanta	
Coast Clinical Society	E. T. McCafferty, Mobile, Ala.	Theo. Middleton, Mobile, Ala.	Mobile, Ala., Oct. 18-19, '56

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Columbia	Thomas H. Bates, Lake City	Clifton G. York, Lake City	1st Mon.	11
**Baker*				
Dade	Hunter B. Rogers, Miami	Vincent P. Corso, Miami	1st Tues.	770
DeSoto-Hardee-Highlands-Glades	Merle C. Kayton, Wauchula	Roland W. Banks, Wauchula	1st Tues.	27
Duval	Joseph J. Lowenthal, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	315
**Clay*				
Escambia	Gretchen V. Squires, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	104
**Santa Rosa*				
Franklin-Gulf	Harold B. Canning, Wewahitchka	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	James N. Patterson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	203
Indian River	Vernon L. Fromang, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	10
Jackson-Calhoun	Richard H. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	18
Lake	Geoffrey H. Binneveld, Leesburg	J. Basil Hall, Tavares	1st Wed.	34
**Sumter*				
Lee-Charlotte-Collier-Hendry	Joseph L. Selden Jr., Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	46
Leon-Gadsden-Liberty-Wakulla-Jefferson	Robert H. Mickler, Tallahassee	Odis G. Kendrick Jr., Tallahassee	Quarterly	71
Madison	Candler K. Hayes, Madison	Wilmer J. Coggins, Madison		8
Manatee	Richard V. Meaney, Bradenton	Eugene E. Biel, Bradenton	2nd Tues.	29
Marion	William J. McGovern, Ocala	Robert L. Gibson, Ocala	3rd Tues.	33
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Monroe	Allen Shepard. Key West	William R. Ploss, Key West	1st Thurs.	13
Nassau	Benjamin F. Dickens, Fernandina Bch.	David D. Bennett, Callahan	Last Fri.	9
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Pinellas	Percy H. Guinand, Clearwater	Whitman C. McConnell, St. Petersburg	1st Mon.	249
Polk	James T. Shelden, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	111
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Suwannee	Shirley L. Hadden, Live Oak	Hiram B. Curry, Jasper	1st. Sat.	12
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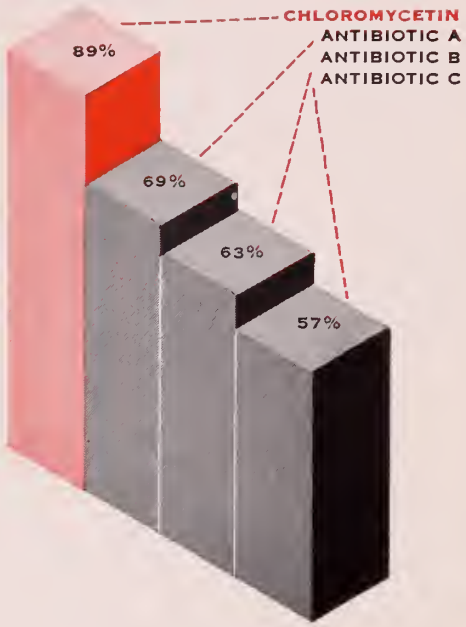

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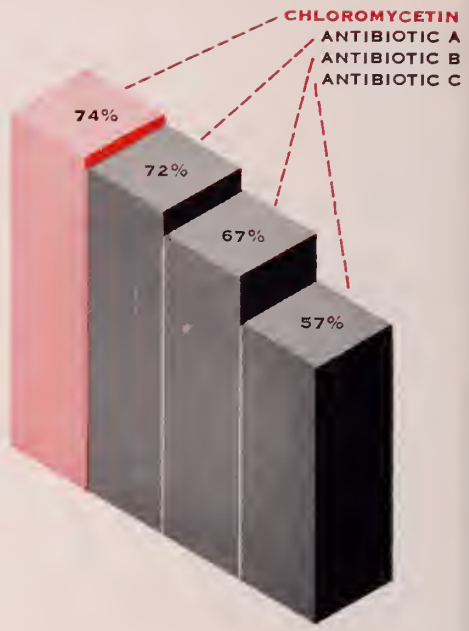

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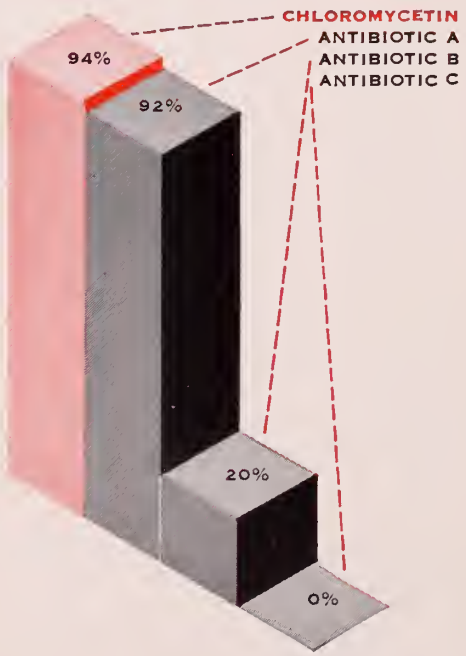

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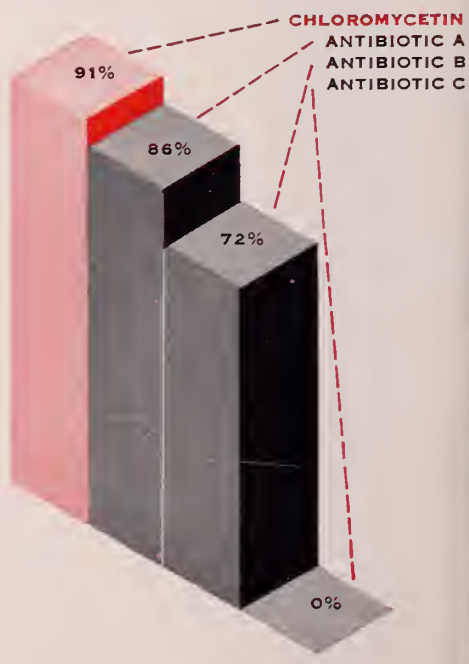

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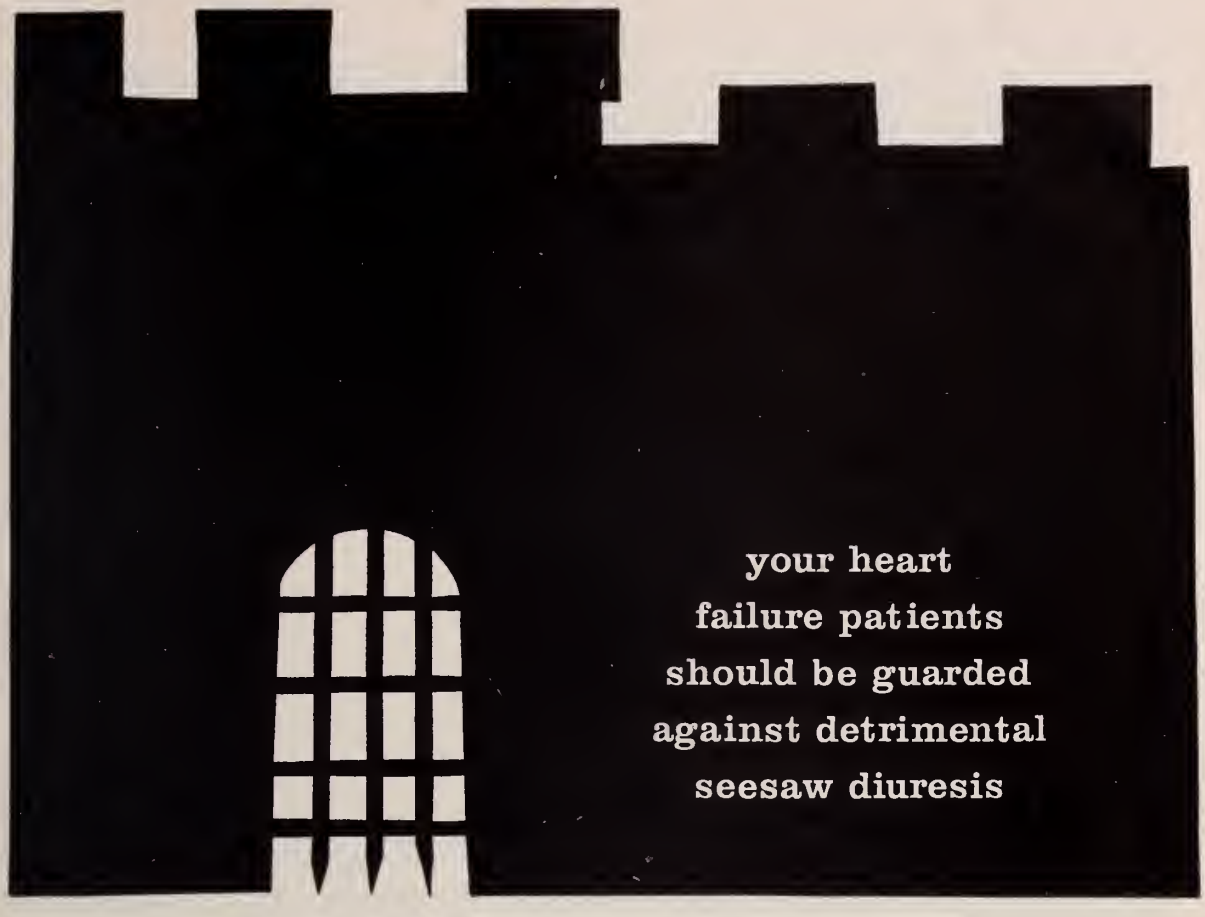

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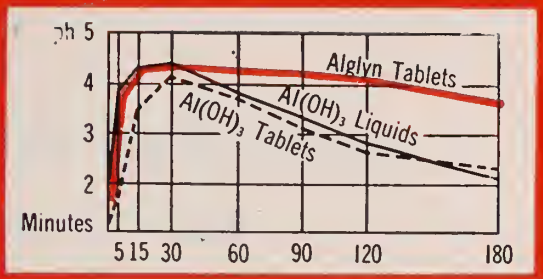

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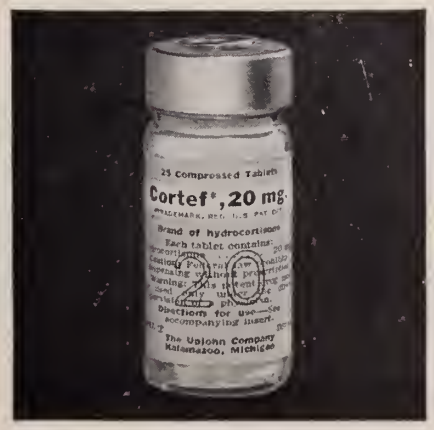

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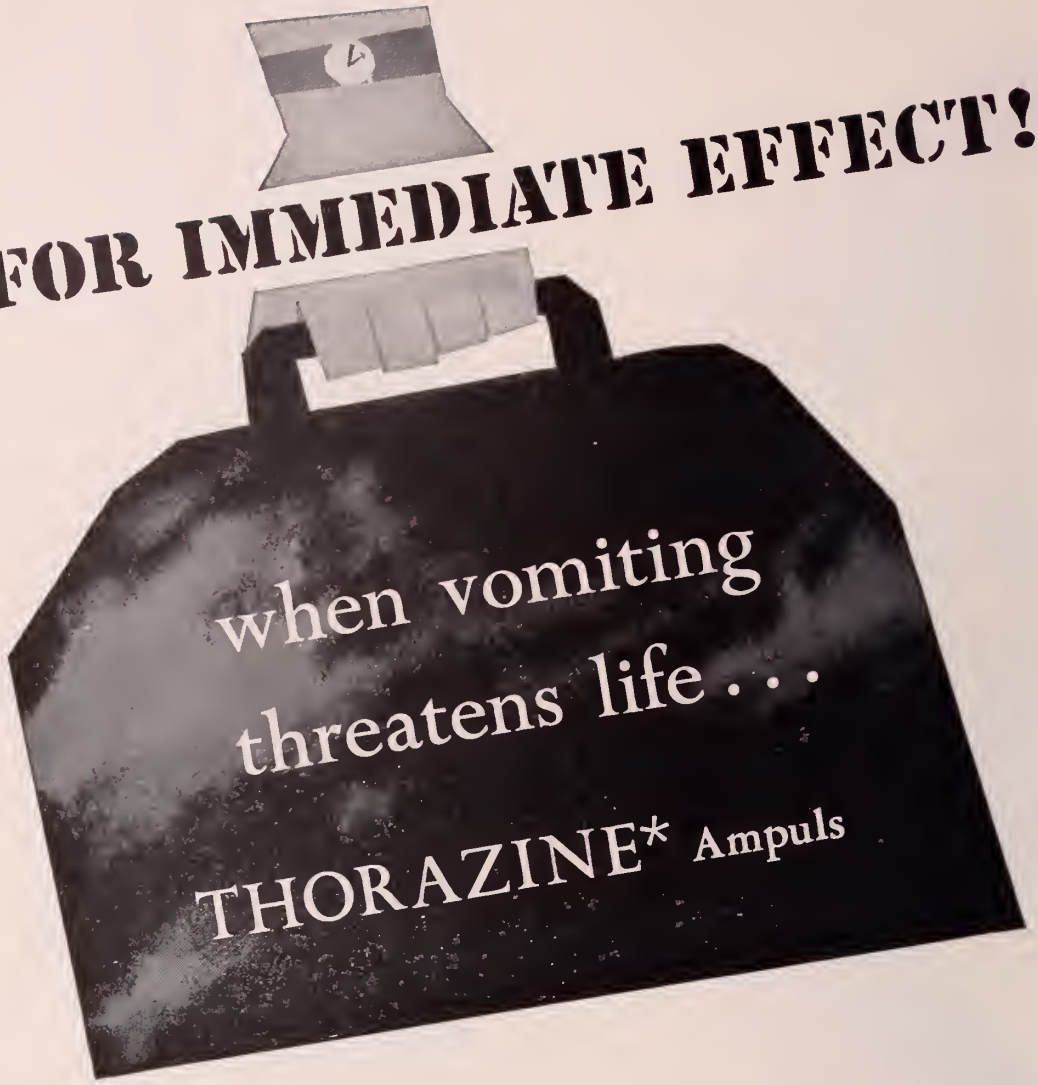

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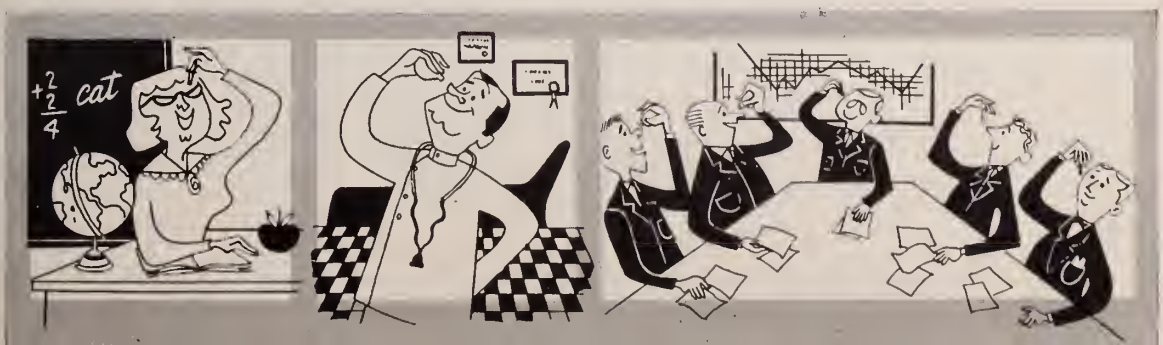

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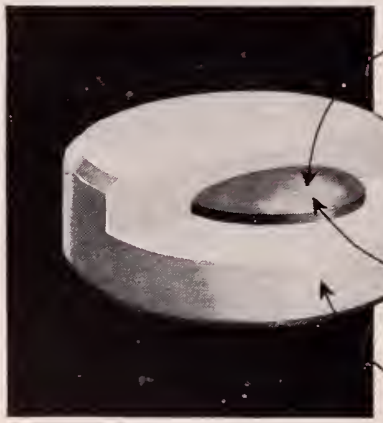

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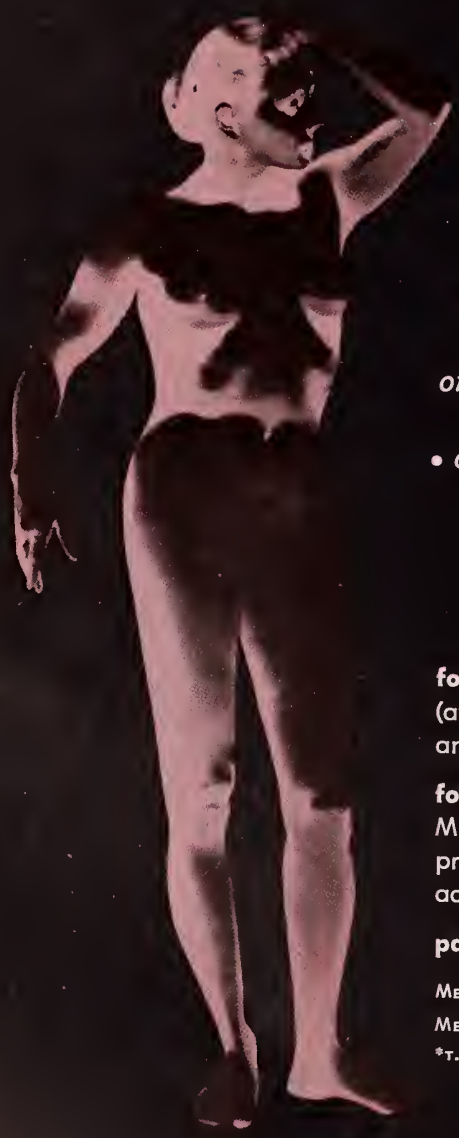

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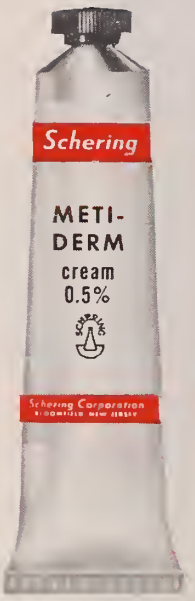

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The Treatment of Chronic Uremia

WARREN LINDAU, M.D.
CORAL GABLES

This paper will be limited to a discussion of the treatment of the patient with uremia due to irreversible chronic renal disease. It is taken for granted that the doctor has ruled out the potentially reversible causes of chronic renal failure, such as urethral stricture, prostatic hypertrophy and sarcoidosis.

There are three fundamentals of therapy — sodium replacement, adequate fluid intake, and the forced high caloric, low protein diet.

Sodium Replacement

Decreased body sodium is accompanied by decreased plasma volume. They cause decreased renal blood flow and glomerular filtration, hence, decreased kidney function.

In most cases of chronic renal failure the tubules have lost some of their ability to conserve sodium. Furthermore, various causes may bring about sudden loss of sodium and precipitate obvious far advanced uremia even in the previously asymptomatic patient. These include indiscriminate use of the low salt diet in all hypertensive patients, which can be fatal to the patient in uremia; acute gastroenteritis with vomiting or diarrhea; and also excessive sweating, Wangensteen suction and mercurial diuretics.

The patient with sodium depletion may complain of weakness or cramps in his legs. If he is dehydrated, ask him if he is thirsty. Predominant water loss causes thirst; predominant sodium loss can result in severe dehydration without thirst. Physical examination may reveal lethargy, in severe cases manifesting itself in apparent mental dullness (fig. 1). This is in contrast to the mental state due to water loss, in which the patient may be in a state of wild confusion. Determine the presence or absence of orthostatic hypotension (fig. 2). Significant orthostatic hypotension in a young person is highly suggestive of sodium loss.

The diagnosis of sodium depletion may be confirmed by performing a serum sodium or a total base determination. The total base determination is composed of all the cations — sodium, potassium, calcium and magnesium. The only cation that fluctuates much, however, is the serum sodium. The total base determination has a great advantage in that it may be accurately performed in smaller communities and laboratories which do not have a flame photometer. An excellent kit[1] can be purchased from the Rochester Products Company, Rochester, Minn., for $55. The technician without much formal training (or the doctor) can easily learn to perform this procedure. Its use should be more widespread than it is.

If there is clinical evidence of sodium depletion and this is confirmed by the laboratory, there usually will be no doubt that sodium therapy is indicated. Sodium depletion, however, plus corresponding water depletion may result in a normal laboratory report. This, of course, is due to the fact that one can only measure the concentration of sodium in a unit of blood. Radioisotope studies in such a case would reveal a low total body sodium. If, therefore, there is clinical evidence of sodium depletion, sodium is indicated even if the serum sodium or total base determination is normal. The laboratory tests, however, are invaluable when the clinical evidence is not conclusive.

The method of administering sodium depends upon the patient's clinical state. An ambulant patient with moderate fatigue and leg cramps can be given 3 to 4 Gm. of sodium bicarbonate; ordinary kitchen baking soda is most satisfactory. The patient in an apparently terminal state with severe sodium depletion, dehydrated and vomiting, will need intravenous sodium. The dose can be calculated by a mathematical formula; however, I have found administration of about 200 to 280 milliequivalents of sodium lactate with frequent re-evaluation, every eight hours in a critical case, equally satisfactory. The concentration of sodium lactate depends upon the relative sodium and water deficits. It can range from undiluted molar sodium lactate to one-sixth molar sodium lactate.

Clinical Instructor of Medicine and Pharmacology, University of Miami School of Medicine.
Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami, May 14, 1956.

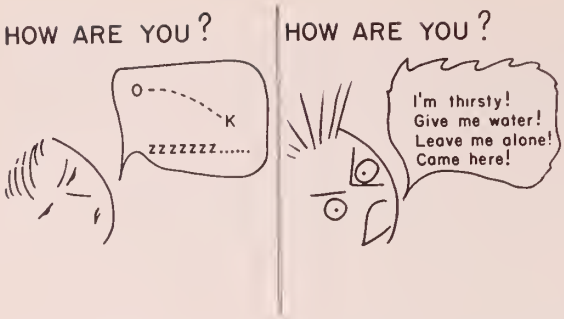

Fig. 1. — The cartoon on the left represents the response of the patient with predominant sodium depletion; on the right, of the patient with predominant water loss.

A 5 per cent solution of sodium chloride and its dilutions, and combinations of sodium lactate and sodium chloride are also used. Watch the patient closely (physical examination, weight and laboratory studies) and do not be reluctant to change treatment.

Adequate Fluid Intake

The kidney has to excrete about 35 Gm. of waste matter daily. The normal kidney can dissolve 1 Gm. of this waste in 15 cc. of fluid if it has to do so. As the kidney's ability to concentrate decreases, however, increasing amounts of water are required to carry each gram of urinary solute in solution. The chart of Lashmet and Newburgh,[2] shown in figure 3, conveys the idea well. Increasing amounts of water are required as the concentrating ability of the kidney decreases. Furthermore, one does not wish to force the kidney to work to its maximum concentrating power; so more than the minimum amount of fluid should be given. The intake should not be carried to the other extreme. Do not waterlog the patient by giving more fluids than can be filtered through the remaining glomeruli. I instruct my ambulant patients to take sufficient fluids to maintain the urine output at a certain amount daily. This ranges from 2 to 3 liters, depending upon the concentrating ability of the kidney and whether there is infection or other catabolic stimulus that breaks down the tissues and increases the amount of urinary solutes. There is no significant advantage in making the ambulant patient go to the trouble of measuring the intake.

Nocturia may result in sufficient dehydration to cause nausea on awakening. Some water at bedtime is a good precaution.

Incidentally, I see a death every year or two following the deliberate dehydration incident to a urine concentration test. This, or any other deliberate cause of dehydration, must be scrupulously avoided.

Forced High Caloric, Low Protein Diet

Low protein diets were a subject of controversy for many years. Obviously, if a form of therapy remains controversial after several years of extensive use, the value, if any, is little.

It is now known that those diets were faulty because they were both low in protein and low in calories; therefore, the patient broke down his own body proteins, with the same sequelae as if he were breaking down ingested protein. It is now obvious that that result can be prevented if the low protein diet is also a forced high caloric diet.

Attention was first directed to this diet by Borst.[3] The original, unmodified Borst diet consists essentially of butter and sugar. An excellent discussion of this diet was presented by Kolff.[4] It contains 2 Gm. of protein and 1,775 calories per day. Its use is limited to short periods in critical problems. The diet is prescribed as a "forced," high caloric, low protein diet because it has to be forced to be effective. The sick patient will not take the unpleasant mixture of his own accord. If the entire amount is not consumed, the

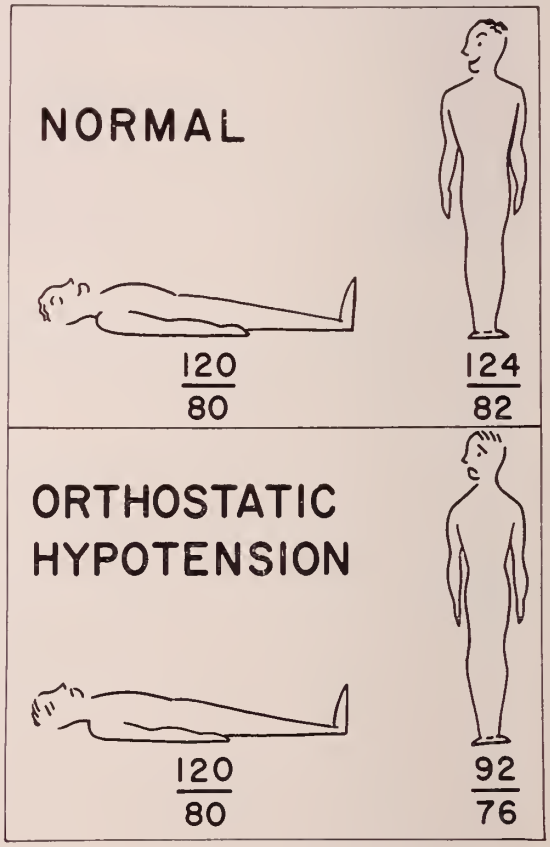

Fig. 2. — This illustration emphasizes the importance of determining the presence or absence of orthostatic hypotension.

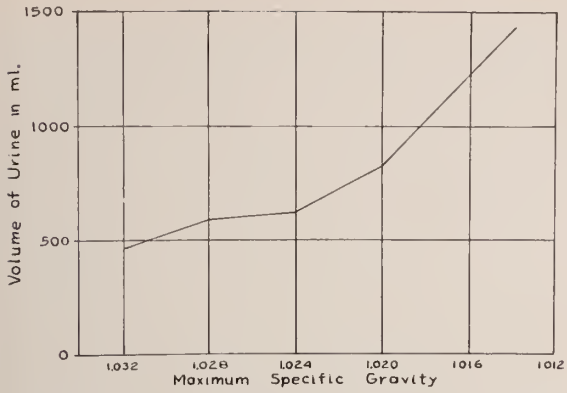

Fig. 3. — An increasing volume of urine is required to excrete the urinary solids as the concentrating ability of the kidney decreases. (Lashmet and Newburgh[2])

patient will have a low protein, but also a low caloric diet, and will break down his own body protein. It therefore must be forced. This usually means that the doctor must do the forcing. Writing the order on the hospital chart and leaving is worthless. Sometimes much ingenuity is necessary to make the patient swallow such a preparation.

Any modification of this diet can be devised, of course. The addition of rice, potatoes or pancakes, for example, makes it much more palatable without adding much protein. Long term use, however, probably requires a minimum protein consumption of 40 Gm. I have rather arbitrarily followed a rule of not prescribing any such regimen in ambulatory patients unless the blood urea nitrogen cannot be lowered below 50 mg. by other means.

If the patient is doing all right, do not risk the possibility of iatrogenic complications just to lower the blood urea nitrogen. These are potent, potentially lethal, therapeutic measures that have been discussed, and if the patient feels well, leave well enough alone.

There is not time to discuss the management of the many complications that may occur. I want, however, to mention the following:

The nausea and vomiting may be due to sodium depletion. Investigate that before taking the risk of dropping the blood pressure with parenteral Thorazine. Do not transfuse just to satisfy the urge for a normal laboratory report. The anemia may be a compensatory process. I only transfuse if the anemia has caused symptoms or complications. It has been suggested that the hematocrit reading be maintained above 25 per cent.[5]

Summary

The three fundamentals of therapy are: sodium replacement, adequate water, and a forced high caloric, low protein diet. These measures, however, will fail unless the doctor abandons the usual hopeless attitude when confronted with the sick uremic patient and is willing to work hard and assume personal supervision of many details. These details will frequently be the difference between rapid death and returning a man to work.

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Discussion

Dr. Elwyn Evans, Orlando: Dr. Lindau limited his paper to uremia due to irreversible chronic renal disease and covered the main points well. There are a number of complicating factors such as hypertension, myocardial failure and infection, but in the time allotted Dr. Lindau wisely limited his discussion to three fundamentals of treatment: sodium replacement, adequate fluid intake and the forced high caloric, low protein diet.

It might be well to mention that it is often difficult to determine reversibility or irreversibility of kidney disease.

Infection needs immediate and adequate treatment.

Although sodium is the only cation that fluctuates much, other cations may be important in certain cases. The body does not tolerate the wide variations of serum potassium above or below normal that it does for sodium. It has been stated that the administration of sodium or potassium may be inadvisable in chronic renal disease, but their use in many patients may be beneficial.

Potassium is generally considered to be contraindicated in chronic renal disease, but it may be depleted in patients with severe acidosis and the associated loss of fixed bases, particularly in patients receiving parenteral fluids only. In comatose patients it may be necessary to add 2 to 4 Gm. of potassium to some infusions, but only when the serum potassium is normal or low with adequate renal function and a stable circulation. In rare potassium-losing nephritis, symptoms may simulate familial periodic paralysis, and treatment must be more strenuous. Hyperkalemia may occur occasionally when large amounts are given in the presence of decreased urinary volume. Forcing of potassium-rich citrus juices to correct dehydration in uremia may cause trouble. Hyperkalemia should be treated with large quantities of glucose, which moves the potassium into the cells. The process is hastened by the use of insulin, and toxic effects are decreased by increasing sodium levels.

In chronic uremia considerable depletion of body and cellular sodium may occur despite normal serum levels. Often the administration of hypertonic alkaline sodium solutions such as sodium bicarbonate or lactate, orally or parenterally, decrease the blood urea nitrogen, decrease serum chlorides which are often elevated, decrease acidosis and elevate the carbon dioxide combining power as well as improve the clinical condition of the patient. In patients with chronic uremia, acidosis and edema associated with depletion of body sodium, the edema frequently subsides after the administration of hypertonic alkaline sodium solutions. There may be cellular dehydration and sodium depletion in the presence of extracellular hydration and edema. Sodium bicarbonate causes

a shift of sodium into the cells and facilitates the excretion of chlorides. The lactate anion is a precursor of bicarbonate and has similar effects.

With the use of calcium lactate or gluconate, hypertonic sodium lactate and occasionally potassium orally or intravenously in 20 patients with advanced uremia and acidosis, Neubauer did not induce hypertension or aggravate existing hypertension, and no patient experienced peripheral or acute pulmonary edema despite body retention of sodium.

In conclusion, if the usual methods of treating chronic uremia are unsuccessful, the recommendations of Dr. Lindau, or some modification of them, should be tried.

DR. LOUIS LEMBERG, Miami: Not too long ago, Peters remarked that the term uremia had a defeatist ring which fosters complacency and routine procedure rather than thoughtful action. Dr. Lindau clearly recommends and practices thoughtful action. In the past and also at the present time, many of us adopted and now adopt a hopeless attitude toward chronic renal failure with uremia, and it cannot be re-emphasized too many times that a properly managed patient with chronic uremia can live many more years as an asset to society.

The level of the blood urea nitrogen and nonprotein nitrogen may not always reflect accurately the reserve of functional renal tissue. As was mentioned, such factors as dehydration, hyponatremia and excessive protein catabolism may increase falsely the levels of nonprotein nitrogen and blood urea nitrogen and thus be an inaccurate guide. If one divides funtionally the renal parenchyma into three, first glomeruli, second, proximal renal tubules and third, distal renal tubules, one may by using various tests get a rough measurement of the functional area involved. This is important in differential diagnosis, as has been brought out by the past two speakers, in that some renal failures are reversible, and the differential diagnosis as to the etiology of the uremia may well be important. Glomerular function can roughly be measured by the nonprotein nitrogen or the urea clearance. The phenolsulfonphthalein test can give a rough measure of the proximal tubule function in the first 15 minutes of the test and in the last 15 or 30 minutes of the test is a guide to the renal plasma flow. The concentration test is a fairly good measure of the function of the distal tubules. For example, in glomerular disease such as glomerular nephritis, lupus erythematosus, Kimmelstiel-Wilson disease and polyarteritis nodosa, the nonprotein nitrogen level as well as the results of the phenolsulfonphthalein test may be abnormal whereas the concentration itself may be normal. In pyelonephritis, especially in the early stages the nonprotein nitrogen level may be normal, and the concentration test will be abnormal.

I have enjoyed Dr. Lindau's paper very much. He has brought out two especially important factors: (1) He has given us a sound, logical, fundamental therapy for a usually most difficult problem. (2) He has given us optimism in the treatment of our patients with chronic uremia.

Primary Varicella Pneumonia

Report of Two Cases

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That chickenpox may be a severe disease, especially in adults, is not generally appreciated. Its usual course is so benign and complications occur so rarely that the potential severity of pulmonary manifestations may not be anticipated. While encephalitis is well known as a possible, though comparatively rare, complication of varicella, it is not commonly realized that pneumonia occurs more frequently. Textbooks have long ascribed this complication to a secondary bacterial invader, which may be aspirated from ulcerating lesions in the upper respiratory passages. It is now, however, beginning to be realized that more often the pneumonia associated with this disease is of virus type and presumably due to the invasion of the lungs by the virus of chickenpox.[1]

The pathologic basis for this conclusion is established by reports of a general dissemination of varicella lesions in fatal cases coming to autopsy.[2,3] Four fatal cases of primary varicella pneumonia in adults, with autopsy, have been reported.[4-7] As a striking feature of the postmortem examination in his case, Claudy[5] described "what were apparently varicella pocks on the pleura, within the pulmonary tissue and on the peripheral portions of the liver and spleen," with microscopic examination confirming the apparently pocklike nature of these lesions. Frank[6] and Eisenbud[7] reported the presence in their cases of characteristic type A intranuclear inclusion bodies of varicella in alveolar septal cells and macrophages, and in bronchiolar epithelial cells. Otherwise, in all 4 of these cases the findings were similar to those observed in other types of virus pneumonia. One of 2 cases reported herein terminated fatally. At autopsy the pock lesions of varicella were present in the lungs, trachea, large bronchi and various parts of the gastrointestinal tract; focal arteritis and in situ thrombosis also were present. In addition, the characteristic intranuclear inclusion bodies of varicella virus were demonstrated in the intra-alveolar septal cells.

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In their study of complications in varicella, reported in 1935, Bullowa and Wishik[8] recorded 21 instances of pneumonia in 2,534 cases, an incidence of 0.8 per cent. Complications occurred in 5.2 per cent of all cases, pneumonia representing one seventh of them. These authors attributed death in only 1 of 11 fatal cases to pneumonia, complicated by septicemia. Later Waring, Neubuerger and Geever[4] obtained details of 8 of these cases. In all, on postmortem examination slight to severe lobular pneumonia was evident, reported to be in no instance "of a peribronchial type, which is considered characteristic of virus pneumonia." One of these patients was an adult 30 years of age.

In 1927, Mitchell and Fletcher[9] reported 4 cases of complicating bronchopneumonia in a series of 775 cases of chickenpox. An outbreak of the disease among natives in the French Cameroun was reported by Millous[10] in 1936. There were 1,919 cases, with adults outnumbering children, and 370 deaths. No pathologic studies were included in the report, but death in the fatal cases was recorded as due to nephritis and uremia, or to severe laryngitis with prominent dysphagia and dyspnea.

Among the 775 patients in the series reported in 1927 by Mitchell and Fletcher,[9] 19.4 per cent were over 20 years of age. Less than 10 per cent of 2,200 patients in a series of cases of chickenpox analyzed by Shuman[11] in 1939 were over 20 years old. In a personal communication to Waring and his associates,[4] this author stated there were several cases of pneumonia among the adult patients, adding that "this was incidental" and that none were fatal. In 522 cases, or 1.78 per cent, of 29,250 cases in a series reported in 1903 by von Genser,[12] the patients were over 14 years of age, 70 of them over 30 years. In citing these series, Waring and his associates[4] observed that 4 of 5 patients with chickenpox hospitalized within a 12 month period at their hospital were adults, all over 26 years of age.

These authors, reporting 2 cases in 1942, apparently were the first to suggest the occurrence of primary varicella pneumonia and definitely ascribed their fatal case to this cause on the basis of histologic examination. Hemoptysis, encephalitis and nephrosis accompanied the acute bronchopneumonia in this case. Similarly, they thought the conclusion seemed justified in the second case that the bronchopneumonia was due to the virus of chickenpox, but since there was rapid response to "convalescent streptococcus serum," they were not inclined to discount entirely the role of a secondary invasive bacterial flora in the causation of the pneumonia. In the available literature 17 cases of pneumonia in adults caused by the varicella virus have been reported. This number includes the second case of Waring and his associates,[4] in which in all probability the pneumonia was due to the virus of chickenpox, although perhaps complicated by secondary invaders. Our 2 cases increase the total to 19. There were 5 fatalities, a mortality rate of 26.3 per cent. In 1943, the year after Waring and his associates[4] reported the first 2 cases, Rausch, Grable and Musser[13] reported 1 case, and in 1947 Grayson and Bradley[14] and Claudy[5] reported 1 case each. Bunn and Hammond[15] reported 2 cases in 1950, and Frank[6] and Wesselhoeft and Pearson[16] 1 case each. In 1951, Michel, Coleman and Kirby[17] reported 1 case and in 1952 Eisenbud[7] 1 case. Six cases were reported in 1953, 1 by Rosecan, Baumgarten and Charles,[18] 3 by Saslaw, Prior and Wiseman,[19] 1 by Stegeman[20] and 1 by Southcott.[1] The ages of the patients in the 19 cases ranged from 23 to 71 years, averaging 36 years. There were 14 men and 5 women, a ratio of approximately 3 to 1.

Clinical Features

Rosecan and his associates[18] summarized in tabular form the details of the cases reported up to that time and added in an addendum that the 3 cases reported by Saslaw and his associates,[19] after their paper was submitted for publication, all presented the typical clinical and roentgenologic features reviewed in their paper. The remaining cases, 1 reported by Stegeman,[20] 1 by Southcott[1] and our 2 cases, likewise conformed to the general pattern. The clinical features were strikingly similar. The pulmonary involvement occurred during the invasive stage of the exanthem, appearing soon after the eruption of vesicles. An alarming, rapid onset of dyspnea and tachypnea, fever and cough within two to six days of the first appearance of the chickenpox rash was characteristic. In addition to the usual findings of virus pneumonia, the cardinal symptoms were the severe dyspnea, cyanosis with pronounced tachycardia, and hemoptysis. In several cases there was gross hemoptysis. Vasomotor collapse occurred in some cases. Many moist rales were scattered throughout the lung fields, with transient areas of bronchovesicular and bronchial breathing. In numerous instances, however, the physical findings were surprisingly few on percussion and auscultation of the chest in view of the pathologic changes demonstrated roentgenologically. The

symptoms of pulmonary complication in some cases preceded physical signs by several hours, especially in the case with heart failure reported by Rosecan and his associates,[18] in which medical shock was present for 10 hours prior to the appearance of rales. In their case only was there detailed evidence of heart failure, but in 2 other cases[4,5] also digitalization was necessary. Pleurisy occurred in several cases.

The laboratory studies indicated that the leukocyte count was somewhat depressed or only slightly elevated, ranging from 4,000 to 14,000, with the differential count practically normal. Significant pathogenic bacteria were not isolated from the sputum. In a few instances in which potential bacterial pathogens were present, adequate chemotherapy was given early. When blood cultures were taken, they were sterile.

The roentgen findings of the chest were characteristic. Uniformly, they demonstrated a diffuse nodular type of pneumonic infiltration, widespread in both lungs, in sharp contrast to the few findings on physical examination. Usually, this condition resolved slowly, although in our case with recovery the resolution was rather rapid.

Various antibiotics were used in treatment, notably Aureomycin. In our first case Terramycin was administered and in the fatal case Achromycin. Southcott,[1] in his comprehensive presentation of the subject of chickenpox pneumonia, observed that there was little evidence that any of the antibiotics in common use have any effect upon uncomplicated varicella, but he concluded that the response in severe and complicated cases to the newer antibiotics appears to be "almost universally favorable." He advised a trial of Aureomycin therapy for in his case it produced dramatic response. Evidence of the beneficial action of this antibiotic, however, is not conclusive although other authors[15,17] have advised its use. The therapeutic role of the newer antibiotics in cases of chickenpox and other diseases of virus origin such as measles and mumps has not been fully evaluated.[17]

Report of Cases

Case 1.—W. D. S., a white man 35 years of age, complaining of fever, malaise, severe cough, tightness in the throat and a rash over the body was admitted to St. Luke's Hospital on Feb. 21, 1954, on the service of Drs. Elmer E. Leitner and Samuel J. Alford Jr. He related that he had had a cold for five days and that three days prior to admission there had developed an eruption of chickenpox, contracted from his 6 year old daughter 10 days after the exanthem of this disease had manifested itself in her. Since the preceding day he had had a severe, almost constant cough with associated dyspnea and raising of large quantities of sputum.

Fig. 1. Case 1. — Roentgenogram of the chest showing extensive bilateral bronchopneumonic type of infiltration of the lungs, more severe in the hilar regions and bases, due to varicella virus.

On physical examination, the patient was a well developed and well nourished man, acutely ill and harassed by a persistent cough productive of thick mucus. The temperature was 101 F., the pulse rate 88, and the respirations 44 per minute and shallow. The blood pressure was 130 systolic and 85 diastolic. Practically the entire exterior surface of the body was covered with umbilicated vesicles and pustules of chickenpox in the late stages of the eruption. Conjunctivitis was pronounced. Innumerable pustules on the mucosa of the buccal cavity and throat were associated with 3 plus edema and tenacious mucus. There also was slight enlargement of the anterior and posterior cervical lymph nodes. Many coarse rales and rhonchi were heard throughout both lungs.

On the roentgenogram made with the mobile unit at the time of admission, extensive blotchy nodular shadows involving both pulmonary fields indicated a severe bronchopneumonia (fig. 1). There was evidence of a greater concentration of the infiltration with coalescence of density in the bases of the lungs.

Urinalysis gave negative results. The red blood cell count was 6,450,000, the hemoglobin estimation 17.2 Gm., and the white blood cell count 9,600 with 1 per cent basophils, 15 per cent stab forms, 40 per cent segmented forms, 42 per cent lymphocytes and 2 per cent monocytes. No blood culture was made.

Treatment administered every four hours consisted of 250 mg. of Terramycin, hot saline gargles, and 50 mg. of Pyribenzamine; other drugs were administered for symptomatic treatment. On the second day of hospitalization it was necessary to resort to oxygen therapy. The temperature returned to normal on the third day and continued virtually so during the remainder of the period of hospitalization.

Roentgen examination of the chest on February 24 indicated slight clearing of the extensive bilateral bronchopneumonia (fig. 2), and two days later gave further evidence of clearing with only minimal residual mottled infiltration remaining (fig. 3). The patient was discharged on the eighth hospital day.

Case 2. — W. G., a 41 year old cowboy, complained of extreme dyspnea on admission to the isolation ward of St. Luke's Hospital on May 16, 1954. He had experienced malaise six days previously and the next morning had noticed "clear water blisters" on his chest and abdomen, which spread over the remaining surface of the body during the next few days. He described the rash as chickenpox and the lesions as "sore" to pressure but not pruritic. Dyspnea developed some two days prior to admission and became progressively more severe. He thought he had had fever the past few days, but reported only an infrequent nonproductive cough, no pain in the chest and no chills, headache or backache. His daughter had been confined to the home with chickenpox about two weeks before the onset of his illness.

The patient denied ever having had chickenpox or having received smallpox vaccination. There was a history of excision of cervical lymph nodes on the left side in February 1953, with a pathologic diagnosis of malignant lymphoma of the reticulum cell type. A second operation on April 3, 1954, consisted of excision of cervical and axillary nodes on that side, and the pathologic report was Hodgkin's disease.

Physical examination revealed a well developed and well nourished white man, extremely dyspneic but not orthopneic, with cyanosis of the lips and nailbeds. His temperature was 104 F. rectally, the pulse rate was 140, and respirations ranged from 40 to 60 per minute. The blood pressure was 110 systolic and 80 diastolic. He was well oriented with clear sensorium. Widely distributed over the body were erythematous, hemorrhagic, papular lesions from 3 to 10 mm. in size. They were discrete and included the vesicles, pustules, crusts and ulcerations typical of chickenpox. The distribution was thickest over the face, extending to the scalp. There were pustular lesions over the external surfaces of the ears, and ulcerative lesions over the gums, buccal mucosa, palate and pharynx. Conjunctivitis was present, but no ocular lesions were noted. The lesions were also thick over the trunk and present in lesser number on the extremities, genitals and palms. A disagreeable odor emanated from the skin lesions.

Fig. 2. Case 1. — Partial clearing of the pneumonic process two days later.

Fig. 3. Case 1. — Virtual clearing four days after the initial study.

There was no rigidity or venous distention of the neck, but a hard, nontender mass was palpated in the supraclavicular area on the left side. Many rhonchi and coarse rales were heard throughout the lungs, with expiratory wheezes and prolonged expiration. Bronchial breath sounds were heard anteriorly over the upper lobe of the right lung. There was no percussible dullness. Aside from sinus tachycardia and hypoactive reflexes throughout, there were no other significant physical findings.

On the day of admission, the red blood cell count was 7,200,000 and the white blood cell count 12,500, with stab forms 13 per cent, segmented forms 70 per cent and lymphocytes 17 per cent. The hemoglobin estimation was 19 Gm. and the platelet count 108,500. On the following day the red blood cell count was 5,320,000, the hemoglobin estimation 16.5 Gm., and the white blood cell count 14,000, with stab forms 10 per cent, segmented forms 80 per cent and lymphocytes 10 per cent. Culture of the blood gave negative results.

A roentgenogram of the chest, taken with the mobile unit on the day of admission, demonstrated extensive infiltration of both lung fields, representing a severe bronchopneumonia of flocculent type, believed to be caused by the specific virus of chickenpox (fig. 4). Roentgen examination on April 2, six weeks earlier, gave no evidence of pathologic change, even though the patient was known to have malignant lymphoma (fig. 5).

The patient was placed in an oxygen tent immediately upon admission. The cyanosis soon was relieved, but the dyspnea persisted. The administration of fluids orally resulted in a reduction of the temperature to 100 F. The tachycardia persisted although he was given 1.6 mg. of Cedilanid intravenously. The daily administration of 1,200,000 units of penicillin was begun. The next day he was extremely weak and cyanotic. The temperature was 101 F. by rectum, and the pulse rate was 100 to 140 per minute. He remained in oxygen. An evening episode of severe dyspnea was relieved by aminophylline and morphine. The chest sounds grew progressively worse, but the cough remained mild and nonproductive. Fluids were administered intravenously, and 500 mg. of Achromycin was given that night.

Fig. 4. Case 2. — Roentgenogram on May 16, 1954, showing a severe flocculent type of bronchopneumonic infiltration of the lungs of bilateral distribution, due to varicella virus, with death two days later.

On May 18, the third day of hospitalization, the rectal temperature was 102 F. Several cyanotic dyspneic episodes occurred, with some relief from oxygen by mask.

Fig. 5. Case 2. — Roentgenogram of the chest on April 2, 1954, six weeks prior to admission, gave essentially negative evidence.

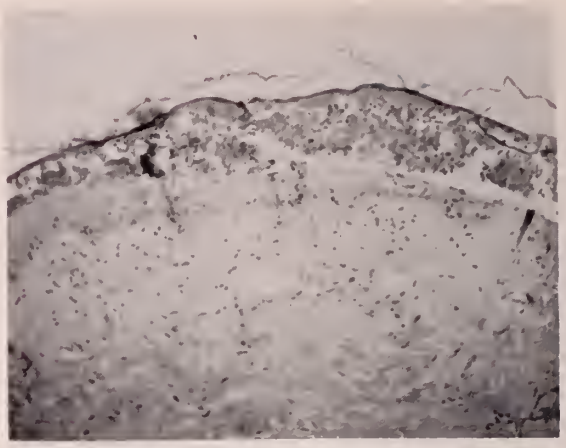

Fig. 6. Case 2. — Photomicrograph of cutaneous vesicle. Hematoxylin and eosin; × 440.

A second dose of Achromycin was given. Increased rattling and bubbling in the chest and mild sternal retraction occurred. The patient remained mentally alert until severe cyanosis with mental confusion followed the administration of 1/6 grain of morphine; Nalline administered intravenously gave some relief. Suddenly, however, he became restless and dyspneic and expired at 2:30 p.m.

Autopsy: At autopsy, performed by Dr. Wray J. Tomlinson, the pertinent gross findings included ulcerated pock lesions on the epiglottis, larynx and trachea. The right pleural sac contained 200 cc. of clear fluid and the left pleura 300 cc. The lungs were heavy, the right lung weighing 1,120 Gm., and areas of hemorrhagic necrosis were present throughout them. The bronchi showed ulceration. In the mediastinum extensive enlargement of hard lymph nodes extended up to the supraclavicular nodal chain. The pale, white, firm nodes showed hemorrhagic necrosis when sectioned. There were no cardiac abnormalities.

The liver weighed 1,520 Gm. and showed evidence of toxic degeneration and congestion, with seven 1.0 to 3.0 mm. subcapsular areas of hemorrhage surrounded by a narrow yellow zone of softening. In the spleen severe toxic changes with congestion of great degree were present and also focal areas of softening measuring 2 to 5 mm. This organ weighed 270 Gm. The adrenals showed toxic softening with minute focal hemorrhages or intense congestion. The right kidney weighed 155 Gm. and the left one 170 Gm. Both were toxic and swollen with focal areas of yellow necrosis measuring 2 to 6 mm. scattered throughout. Focal hemorrhages also were present in the papillae. In the gastrointestinal tract there were ulcerated pock lesions in the esophagus, edematous patches and several small focal mucosal ulcerations in the ileum, and focal ulcerations similar to the pock lesions in the colon.

Microscopically, the pock lesions on the skin, with areas of vessel thrombosis, were those of classic varicella (figs. 6 and 7). These lesions were present in the lungs, as was pneumonia of the virus type (fig. 8). Histologically, the lungs showed considerable evidence of congestion and edema with numerous foci of fibrinous exudate. The edema involved the interalveolar septal walls and the peribronchiolar and perivascular structures. Some of the exudate was also present within the alveoli with hyaline membrane formations. Areas of focal necrosis were evident. The characteristic intranuclear inclusion bodies of varicella virus were present (fig. 9). Macrophages, many of which were multinucleated, were demonstrated. In addition, focal arteritis and in situ thrombosis were observed. There were also varicella lesions of the trachea and large bronchi (fig. 10). The liver presented evidence of toxic hepatitis and focal necrosis; the spleen, toxic splenitis with focal arteritis; the adrenals, toxic hemorrhagic areas; and the kidneys, a severe nephritis. Varicella ulcerations were observed in various portions

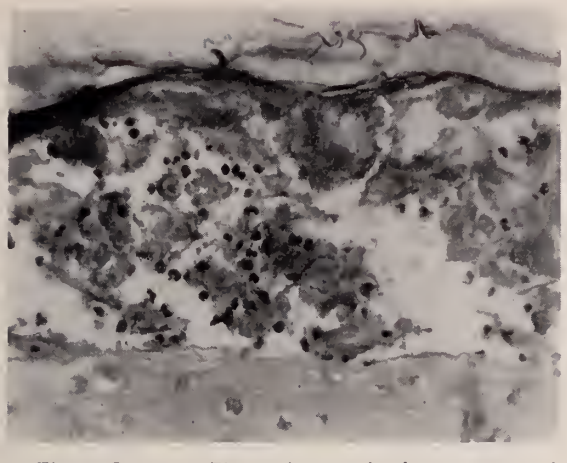

Fig. 7. Case 2. — Photomicrograph of cutaneous vesicle showing large intranuclear inclusion bodies in the ballooned-out strata granulosum and mucosum of epidermis. Hematoxylin and eosin; × 980.

of the gastrointestinal tract. The lymph nodes presented features of lymphosarcoma and Hodgkin's disease.

The cause of death was considered to be varicella pneumonia, with secondary nephritis.

Comment

Although the virus of chickenpox is widely disseminated throughout the body, it rarely produces such visceral manifestations as pneumonia, encephalitis and nephritis. Primary varicella pneumonia, while an infrequent complication, appears from the recent literature to occur more frequently than has been realized and to have a predilection for adults. Also, it is potentially extremely serious as the reported cases carry a high mortality. Parents who have not had chickenpox but whose children have this disease should be alerted to this danger since in our cases and others[4,6,16,19,20] there was a history of a child in the home suffering from the disease a short time before it was manifested in the parent.

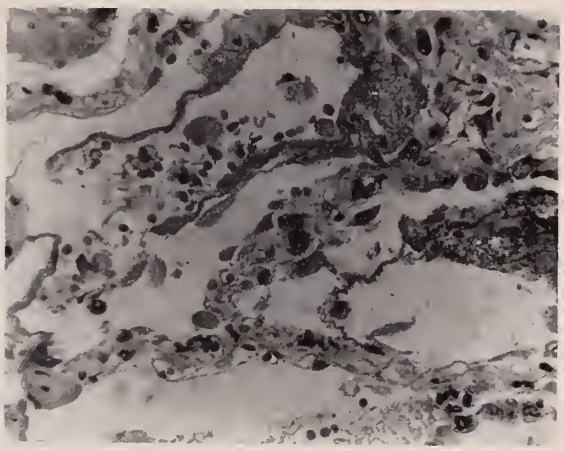

Fig. 9. Case 2. — Photomicrograph of lung, showing fibrinous exudate and epithelial and granular debris in the alveoli, with sequestered hyaline membranes and macrophages. A number of intranuclear inclusion bodies are present in the intra-alveolar septal cells. Neutrophilic granulocytes are rare. Hematoxylin and eosin; × 980.

The response to Terramycin in our first case was excellent. In view of the varicella lesions present at autopsy in the lungs in the second case, as well as the focal changes in many of the viscera, the overwhelming pneumonia can be attributed only to the virus of chickenpox. It was unrelated to the antecedent malignant lymphoma except in the hypothetical sense that the patient may have been more susceptible to the virus than one not so afflicted. Therapy which included penicillin and Achromycin failed to arrest the course of the disease during the short period of hospitalization before death ensued.

Secondary nephritis was severe in our second case, and was a feature of cases reported by other authors.[4,10,14] The visceral lesions of varicella, particularly as they affect the lungs and kidneys,

Fig. 8. Case 2. — Photomicrograph of lung showing pneumonic process. Hematoxylin and eosin; × 120.

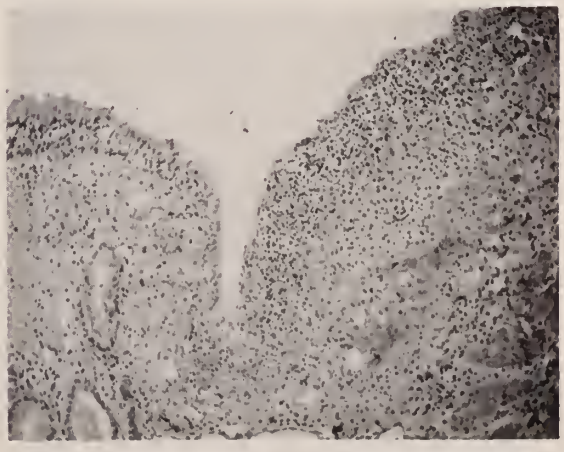

Fig. 10. Case 2. — Photomicrograph showing ulcerative bronchitis. Hematoxylin and eosin; × 440.

must be considered as grave complications, with a high mortality.

Summary

Two cases of primary varicella pneumonia, 1 of which came to autopsy, are reported. They conform to the general pattern of the 17 cases described in the available literature in which the virus of chickenpox was believed to be the cause. This complication appears to have a predilection for adults. It may be extremely severe, for 5 of the 19 cases terminated fatally.

Terramycin was used successfully in our first case. In the second case Achromycin and other therapy proved unavailing in the short time the patient was under treatment. Various other antibiotics were used with more or less success by other authors. The therapeutic value of the newer antibiotics in this type of pneumonia has not been established.

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Surgical Aspects of Jaundice of Nonobstructive Nature

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In considering surgical aspects of jaundice, emphasis usually is placed on obstructive lesions which may be relieved in the operating room. From the standpoint of the internist, we thought it would be presumptuous of us to give the surgeon advice on how to do his job, and Dr. Harrell's paper[1] has covered well the differentiation between medical and surgical jaundice. It seemed that discussion of some problems of jaundice which frequently vex the surgeon and yet cannot be relieved by the knife might be of value.

At the outset, one must recognize icterus. In many slightly jaundiced patients the condition is overlooked in the examining room and probably more in the hospital because of poor or artificial lighting which makes detection difficult or impossible. If at all feasible, each patient should be examined in good daylight.

McNee's classification[2] dividing jaundice into three types affords a good starting point for discussion.

1. Prehepatic, or hemolytic
2. Hepatic, resulting from intrinsic disease or disorder in the liver itself
3. Extrahepatic, resulting from blockage of bile flow outside the liver

It is the third type which the surgeon more frequently can correct, but the first and second groups often cause him greater concern.

Diagnostic Aids

Without attempting a detailed discussion, it seems not superfluous to recount the usually available tests which are most useful in evaluat-

Read before the Southwest Medical District Meeting, Lakeland, Oct. 11, 1955.

ing jaundice: (1) Cephalin cholesterol flocculation, (2) thymol turbidity, (3) serum bilirubin or van den Bergh, (4) fecal and urine urobilinogen studies, (5) alkaline phosphatase determination, (6) cholesterol and esters, and (7) serum proteins and their electrophoretic patterns.

The cephalin flocculation and thymol turbidity are increased in the hepatocellular or medical forms of jaundice.

The serum bilirubin is of less value in differentiating hepatic and extrahepatic disease since both the indirect and direct portion are elevated in each. It is of great value in prehepatic jaundice in which almost all of the bilirubin is of the indirect variety. In complete obstruction of extrahepatic nature bilirubin values often become fixed at a somewhat constant level, whereas in hepatocellular jaundice the level tends to fluctuate. The persistence of an abnormally high level following removal of the biliary obstruction is indicative of severe liver damage and portends a high mortality rate.[3]

Fecal urobilinogen determinations are especially helpful diagnostically in determining if complete extrahepatic obstruction, usually seen only in malignant tumors, is present. If the total fecal urobilinogen for a 24 hour period is consistently below 5 mg., and urine urobilinogen is absent or present only in traces, then one must assume a complete obstruction to bile flow. In such instances the urobilinogen in the urine approaches zero because enterohepatic circulation must cease when no bilirubin reaches the intestine for conversion into urobilinogen.

An alkaline phosphatase level of 10 to 15 units is apt to be found in hepatocellular jaundice. If elevated to levels above 15, obstructive jaundice is usually present.

Free cholesterol and cholesterol esters rise in obstructive jaundice. In serious liver damage, with or without obstruction, the esters are apt to be significantly low. The surgeon should be wary of any operative procedure on a patient who has consistently low cholesterol esters and should recognize that patients with both low total cholesterol and ester values have an extremely high mortality rate.

Until fairly recently, the prevailing feeling has been that the serum proteins become altered only late in liver disease. With the increasing use and more exact knowledge obtained from electrophoretic studies, it is likely that this concept will change and that an additional valuable diagnostic and prognostic tool will be available.

The Bromsulphalein test is of little value since significant degrees of jaundice invalidate the determination.

Diagnostic Problems

Let us now consider some aspects of hemolytic jaundice. Practically all of the bilirubin is of the "indirect" type, the chief differential point distinguishing hemolytic icterus from the other forms. As a result of increased destruction of red cells and resultant excessive bilirubin excretion, gallstones are often produced. The surgeon must be mindful of this possibility in any case of cholelithiasis and particularly so if anemia or significant enlargement of the liver or spleen is present. Such anemia is usually of the simple hypochromic variety, but adequate hematologic studies to define it accurately should be obtained.

Perhaps most distressing to the surgeon is the jaundice appearing several days after operation. Before conjuring up the specters of a ligated common duct, overlooked gallstones, leaking suture lines, and so on, it should be recalled that when transfusions have been employed, the jaundice may result from increased amounts of bilirubin formation subsequent to red cell destruction. Within 24 hours after receiving 500 cc. of blood, some 18 Gm. of hemoglobin are released and 720 mg. of bilirubin are produced.[5] While the normal liver processes only between 7 and 12.5 Gm. of hemoglobin each day, its reserve potential is great, and it can excrete much greater amounts.[6] In the patient who has undergone major abdominal surgery, however, the liver may well have suffered preoperatively. In addition, such factors as surgical trauma, transient shock and anesthesia may have impaired its function. Jaundice may then result rapidly and unexpectedly. Careful consideration also must be given to transfusion reactions, particularly when oliguria or anuria is present.

Another form of icterus which may be disturbing is constitutional hepatic dysfunction, also known as familial nonhemolytic jaundice.[7] Many such cases before presentation to the surgeon have been extensively studied with no cause or remedy found for the jaundice. Ultimately, the family or patient appears in desperation, insistent upon an operation. Such frantic appeals should be tactfully refused since the etiologic factor cannot be corrected by removal of the spleen or other surgical procedure, and evidence is lacking that the condition is harmful to the patient. Apparently the only abnormality is the inability of the liver to excrete bilirubin normally. The Bromsulphalein

excretion and other liver function tests are normal. The increased serum bilirubin is of the "indirect" variety, but in contrast to a true hemolytic anemia there is no anemia, no microcytosis, no increase in reticulocytes nor in red cell fragility, the spleen is not enlarged, and excretion of urobilinogen in the urine and stool is normal. It is an hepatic form of jaundice though it mimics hemolytic jaundice clinically. Lichtman[8] stated the trait may exist in 2 to 3 per cent of the population. This fact alone may explain why occasional patients become jaundiced following a blood transfusion when no incompatibility is demonstrable.

Some of the infectious diseases may pose difficult problems. Infectious mononucleosis occasionally is associated with pain in the right upper quadrant of the abdomen and tenderness which may be acute and severe. These symptoms may occur before splenic enlargement or significant adenopathy is present. In one such case recently observed the disease mimicked an acute cholecystitis to the extent that a surgeon was called in consultation. A low leukocyte count cast doubt upon initial suspicions, and a conservative course was followed. A diagnostic heterophile antibody titer was found, and the illness followed a course typical of infectious mononucleosis with hepatitis. Weil's disease, too, should always be considered in the febrile, jaundiced patient.

One of the most important intrahepatic forms of jaundice that presently must concern all surgeons is that due to chlorpromazine, more commonly known as Thorazine. It cannot be positively distinguished from that produced by extrahepatic biliary obstruction through the use of presently available laboratory studies or even liver biopsy.[9] The flocculation studies for hepatocellular damage are normal. The pathologic picture is one of occlusion of the biliary canaliculi with stasis of bile and varying degrees of inflammatory cellular infiltration but no parenchymatous change. It should be determined in any presenting case which appears to be obstructive in origin whether Thorazine has been taken. Jaundice usually develops after three or four weeks of treatment and often is ushered in by mild to moderate fever, malaise and nausea, but icterus may be the only finding. Rash or itching frequently occurs, and eosinophilia may be present. These findings must be given due consideration, but the proof lies in the subsidence of the jaundice after discontinuance of the drug. The return to normal of the serum bilirubin may take several weeks. Unless the patient becomes rapidly worse, and evidence is sufficient to make it mandatory, surgical intervention should not be undertaken.

It seems advisable to emphasize that obstructive jaundice does not damage the liver cells immediately but only with prolonged distension of the biliary system. Even in infants born with atresia of the bile ducts, hepatocellular function tests may remain normal for several months.[10] The surgeon should be bolstered by this knowledge, not only in consideration of Thorazine but in all his preoperative and postoperative cases in which jaundice develops. It is safer to be conservative until adequate observation and evaluation can be accomplished since the presence of icterus is not necessarily a signal for immediate surgical intervention. More often it is a real challenge to the medical-surgical team, both diagnostically and therapeutically.

More precise laboratory methods, along with better understanding of the jaundiced patient, have already made the management of such cases one of scientific exactness rather than art.

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Citizens Building.

Physicians' applications for registration or re-registration for the special federal tax stamp to dispense narcotics and applications for opium order forms should be directed to: District Director, Internal Revenue Service, Jacksonville, Florida, % Returns Processing Branch.

Tuberculosis Control Program in a Rapidly Growing County

Paul W. Hughes, M.D.
FORT LAUDERDALE

Broward County's population (1950: 83,000; 1955: 159,000) is one of the most rapidly increasing in the United States. Many persons move to this area for their health, and a considerable number are afflicted with pulmonary tuberculosis. A comprehensive tuberculosis control program in its various features is described in this presentation. An attempt also is made to evaluate the measure of control in Broward County over the succeeding years.

Health education emanating from the Broward County Tuberculosis Association and Broward County Health Department has been on a year round basis. The early detection of tuberculosis has been a prominent feature with professional and lay personnel.

A Case Register maintains the continuing status of all known patients with tuberculosis and their contacts. No case is closed out unless the disease has been inactive for at least five years.

A 70 mm. mobile chest x-ray unit operates daily on schedule reaching all parts of the county. X-ray examination is made on all persons over 15 years of age.

Any health card or certificate issued or certified by the health department requires a chest x-ray within the previous 12 months.

A full time nurse obtains 14 by 17 chest x-rays and sputum examinations on any suspect prisoner admitted to the county jail.

Daily service on appointment for 14 by 17 chest x-rays is available. Local radiologists will view immediately any film suggestive of tuberculosis; 70 mm. film is read by the four radiologists in the county. Follow-up 14 by 17 chest x-ray films are obtained when 70 mm. films suggest the presence of the disease.

All persons over 15 years of age admitted to the Negro hospital are given a 14 by 17 chest x-ray unless they have had a chest x-ray giving negative evidence within the previous 12 months.

Skin testing for tuberculosis on all new first graders has been performed since 1952. The past two years this program has been extended to the fourth, eighth and twelfth grades.

Any adult physical examinations performed by the Health Department are required to include chest x-ray. All antepartum patients in the public clinics are required to have chest x-rays.

Tuberculosis clinics are held on schedule in the three health centers. A physician who is a diplomate of the Board of Internal Medicine holds all clinics and is available for emergency consultation.

The hospitals, Welfare Department, Tuberculosis Association and physicians have excellent liaison for the disposition of any newly discovered cases of tuberculosis.

The local Tuberculosis Association has an active rehabilitation committee. This committee has recently recommended that a full time medical social worker be placed in the Health Department to aid in the social and emotional needs of the patient. Vocational rehabilitation services of the government are, of course, used extensively in behalf of the patient when he becomes well enough for such a program.

Approximately 75 to 100 pints of blood per year are obtained from prisoners for patients who need surgery and do not have sufficient donations from friends and relatives.

There is an In-Training Program for Public Health Nurses whereby the nurses spend two full days at the South East Tuberculosis Sanatorium. The purpose of this program is to complete for the public health nurse the follow-up picture of the patient with tuberculosis.

The following data and graphs indicate the extent of control of tuberculosis with the aforementioned program:

Figure 1 shows the receding death rate for tuberculosis designated at yearly and five year levels.

Figure 2 indicates the annual and five year rates of hospital admissions in Broward County for tuberculosis. In 1951 the peak incidence of hospital admissions occurred, and since 1951 the rate has fallen remarkably.

Broward County Health Officer.

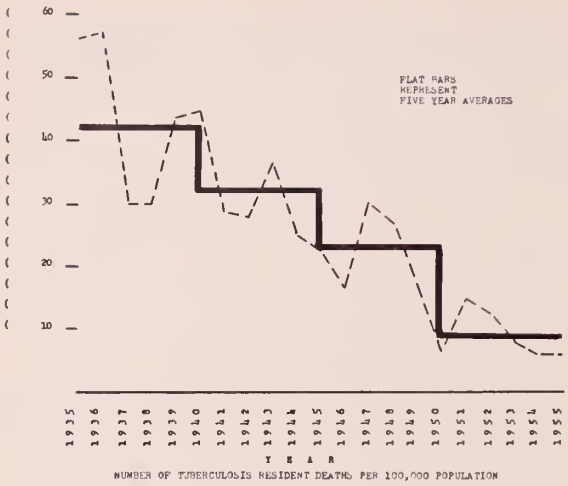

Figure 1.

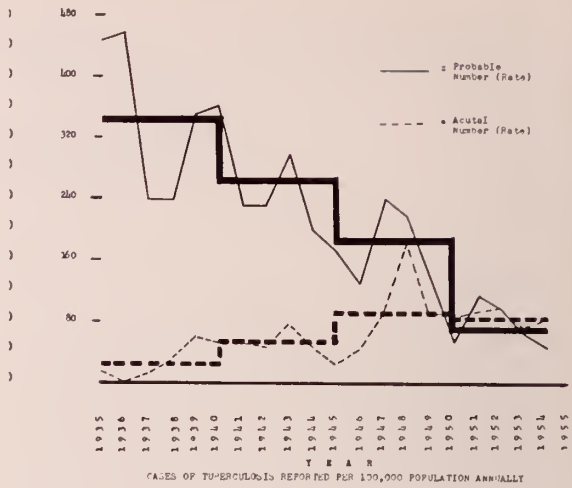

Figure 3.

Figure 3 represents the reported tuberculosis case rate by year and with five year averages (broken lines). If one postulates that for every death there should have been reported eight new tuberculosis cases per year, the probable number of tuberculosis cases (solid lines) as compared with the reported cases (broken lines) show the discrepancy between probable actuality and what was reported throughout the years. It also will be noted that in the last five years this discrepancy has ceased to exist.

Patch tests for tuberculosis were offered to each first grade school child each year since 1952. In 1951, in one white school 80 pupils were tested. The results depicted in figure 4 shows a decline from about 14 to 3 per cent on a countywide basis. Each child having a positive reaction to the skin test is offered a 14 by 17 chest x-ray; and all adults who have been closely associated with the child are advised to obtain 70 mm. films from the mobile unit. It is explained to the adults that they innocently may be the source of the child's infection.

Figure 5 indicates the results of patch testing of first grade children in 1955 according to their district of residence. Superimposed are the tuberculosis deaths and definitely active cases of tuberculosis noted in the past five years. There appears to be a definite correlation between these data and the existence of homes where overcrowding occurs (according to the Sanitation Department's knowledge of housing conditions).

Future Plans

Broward County's future plans to tighten control on the spread of tuberculosis infection are as follows:

A medical social worker, full time, will work with patients having tuberculosis and their families to minimize emotional disorders which may result in deterioration of the patient's condition. At weekly intervals this worker will visit patients

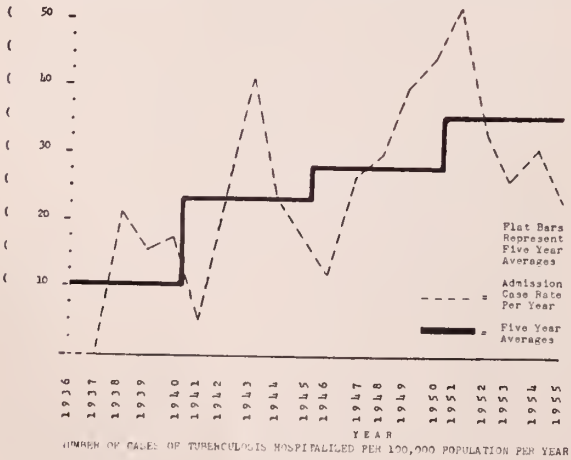

Figure 2.

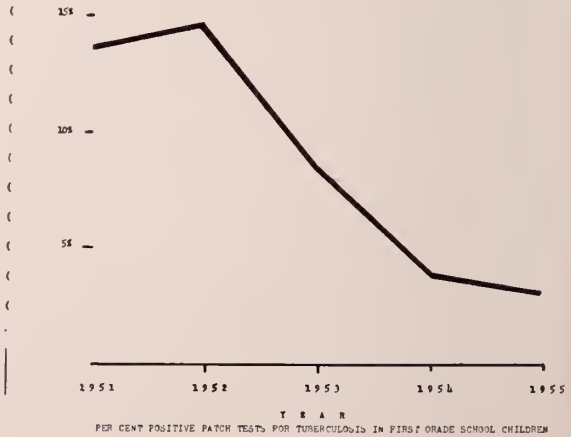

Figure 4.

hospitalized for tuberculosis. She will work in liaison with the Welfare Department, Tuberculosis Association, Health Department, other social agencies and the family doctor.

Skin testing for tuberculosis will be performed on all school children, grades one through 12. The usual follow-up program mentioned heretofore will be carried out. Skin testing of adults will be encouraged so that a legitimate sample will be obtained according to age groups to determine the extent of infection in the community.

Full use of the new disability pension law will be made to help correct some of the economic difficulties of the patient with tuberculosis.

A hospital admission chest x-ray program will be encouraged for the three large hospitals.

With the completion of a new county jail, an inclusive skin test and/or chest x-ray for all new prisoners will be obtained.

Where areas are known to have exceptionally high rates of skin positivity, house-to-house surveys will be made via the mobile x-ray unit stationed in that area.

Employers are to be encouraged in having a program whereby all their employees are x-rayed annually.

Slum clearance programs with suitably replaced housing will be sought.

Continued evaluation of the results of tuberculosis control will be maintained so that the staff will know the "trouble spots" and have some idea as to the progress being made year-by-year in the control program. As adults' skin test positivity declines, the chest x-ray program of the mobile unit may be confined to those persons only who have positive reactions. Public education will continue as to the explanations of the meaning of the positive reaction to the skin test.

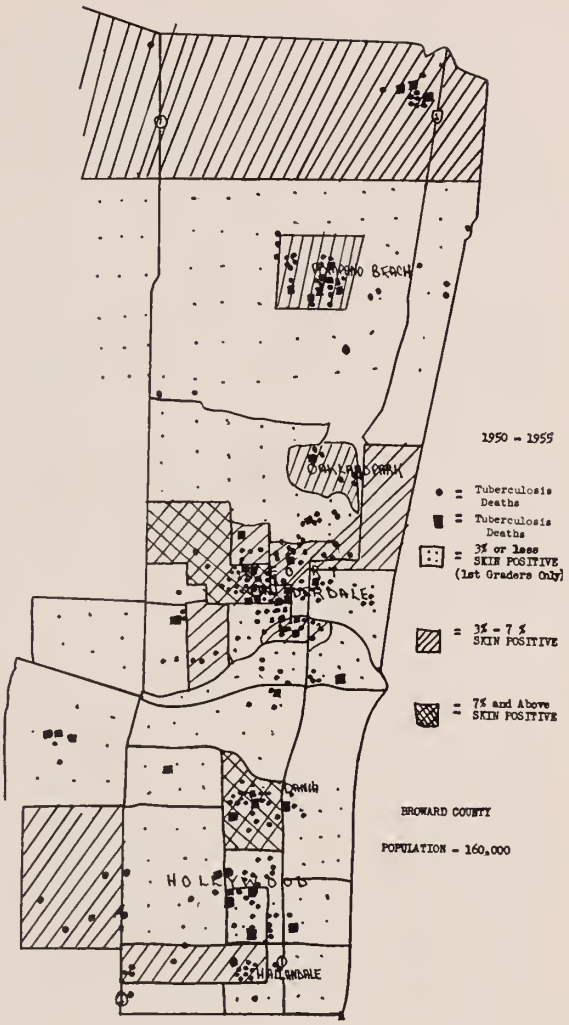

Figure 5.

Box 1677.

ABSTRACTS

Persistent Sore Throat in Tonsillectomized Persons. A Statistical, Etiologic and Therapeutic Study. By A. R. Hollender, M.D., F.A.C.S. Eye, Ear, Nose & Throat Monthly 35:117-137 (Feb.) 1956.

The assumption that tonsillectomy invariably promises cure of "sore throat" is erroneous. As Dr. Hollender has previously pointed out, "sore throat" embraces a multiplicity of pathologic processes. It may develop with an acute primary process of the pharynx itself, or it may be a persistent condition, chronicity resulting from a lingering, more or less obscure focus, or from various other causes. In this study of 200 tonsillectomized persons, the incidence of "sore throat" was 8 per cent higher than in a control group in whom the tonsils remained intact.

The conclusions from this study are: Poor end results of tonsillectomy ascribable to imperfect operative technic account for throat symptoms in a fairly high percentage of patients. Decision for tonsillectomy should be based on the results of a complete examination of the patient and not solely on inspection of the pharynx. Various unrecognized associated pathologic processes frequently are responsible for the persistence of "sore throat" after the tonsils have been removed. Correction of extratonsillar causes promises cure of persistent "sore throat" in the large majority of patients, but in a small percentage, despite exhaustive efforts in diagnosis and treatment, complete freedom from pharyngeal discomfort is never experienced.

Prescalene and Deep Cervical Lymph Node Biopsy. By Richard G. Connar, M.D., F.A.C.S. Surg., Gynec., & Obst. 101:732-743 (Dec.) 1955.

This study was undertaken for the purpose of evaluating (1) the practical value of a prescalene biopsy in establishing the diagnosis in cases with previously undiagnosed intrathoracic lesions and (2) the value of the procedure in preventing unnecessary thoracotomies in cases of carcinoma of the lung, that is, when the malignancy has already spread beyond the limits of surgical excision. Experience is reviewed with prescalene and deep cervical lymph node biopsy in 50 consecutive cases with previously undiagnosed intrathoracic lesions. The lymphatic drainage of the lung and the operative technic are described. The selection of the proper side for biopsy is discussed. Positive tissue diagnosis was established by prescalene and deep cervical lymph node biopsy in nine cases of carcinoma of the lung, four cases of Boeck's sarcoid, and one case of Hodgkin's disease. The incidence of a positive tissue diagnosis was the same (31 per cent) as by bronchoscopic biopsy in the cases with carcinoma of the lung. Undifferentiated carcinoma was the most commonly encountered malignant disease in the prescalene and deep cervical lymph node biopsies. There was a high incidence of positive biopsy in cases of Boeck's sarcoid.

The author concludes that in the case of carcinoma of the lung, if the prescalene and deep cervical lymph node biopsy is positive, exploration should be reserved as palliation for major hemorrhage or infection.

An Analysis of 215 Cases of Bronchiectasis. By G. E. Lindskog, M.D., F.A.C.S., and David S. Hubbell, M.D. Surg., Gynec. & Obst. 100:643-650 (June) 1955.

The objectives of this analysis of a series of 215 consecutive cases of proved bronchiectasis are: (1) to study the etiology, symptomatology, and anatomic distribution of the disease; (2) to define the indications for resectional therapy; (3) to evaluate the results of surgery; and (4) to elucidate the factors predisposing to postoperative complications. The data presented have particular reference to age at onset of the disease and at time of treatment, sex, race, recognized etiologic factors, chief symptoms, anatomic distribution of the disease by lobes and segments, and bacteriology of the sputum. The methods used in clinical evaluation and the criteria for selection of patients undergoing surgery are described.

In 77, or 35.8 per cent, of the 215 cases resectional therapy was not resorted to for the reasons enumerated. In the remaining 138 cases, 165 pulmonary resections of various types were carried out with four hospital deaths, an operative mortality of 2.4 per cent and case mortality of 2.9 per cent. Postoperative complications are tabulated and possible causes analyzed. Late follow-up data are presented in 200 of the original 211 hospital discharges.

Certain factors influencing the prognosis of bronchiectasis are discussed. It is the conclusion of the authors that the superior end results in patients treated by resection as compared with nonsurgical measures are clearly demonstrated.

Ischemic Necrosis of the Anterior Tibial Compartment Musculature. By Roy E. Campbell, M.D., and Col. Frank H. Van Wagoner (MC), U.S. Army. A. M. A. Arch. Surg. 71:662-668 (Nov.) 1955.

Three cases are reported in which idiopathic ischemic necrosis of the anterior tibial compartment musculature without trauma or signs of arterial disease developed in soldiers in Germany aged 21, 30 and 35. Since few cases are reported in the literature and the three here described were observed within a two year period, the authors conclude that the condition probably occurs much more commonly than is recognized. They discuss the most plausible theory of etiology and mention the diagnostic physical findings.

Just as in other conditions of arterial occlusion, they observe, the first few hours of treatment are of the utmost importance. Whereas rest and conservatism may be used if pain is the only symptom, wide fasciotomy and paravertebral blocks must be performed immediately if paralysis of these muscles has occurred.

Esophageal Reconstruction with Dermal Transplants. By Richard G. Connar, M.D. and Kenneth L. Pickrell, M.D. Transplantation Bulletin 2:94-95 (July) 1955.

The authors report the results in 15 mongrel dogs of the reconstruction of the cervical esophagus by employing free dermal transplants. The grafts were taken from the abdomen. The cervical esophagus was exposed through a midline incision, and segments varying from 4 to 6 cm. in length were resected. The dermal graft was made into a tube, with the dermis inside. The tube was used to replace the resected esophagus. In the group without further treatment, the findings at autopsy were consistent, stricture invariably occurring at the distal suture line with dilatation of the proximal esophagus. The graft had contracted in length as well as in width, but was covered with epithelium. There was atrophy of all hair follicles and glands in the dermis. The only difference between this group and the group subjected to esophagoscopy and dilatation was that in the latter the stricture was less pronounced.

The advantages of grafting a tube made of free dermis to reconstruct the cervical esophagus are cited as (1) the use of autogenous material which is readily available, (2) a one stage operative procedure, and (3) a simple and brief surgical technic. It is suggested that the procedure might also be used with a temporary stent in the treatment of carcinoma of the thoracic esophagus in the human, for the dangers from slough of the graft and fistula formation are minimal.

Bronchogenic Carcinoma in Young Men. By Augustus E. Anderson, M.D., Howard A. Buechner, M.D., Isadore Yager, M.D., and Morton M. Ziskind, M.D. Am. J. Med. 16:404-415 (March) 1954.

In this study of bronchogenic carcinoma occurring in a group of 30 men less than 40 years of age, the observations as a whole represent a noteworthy contrast to the manifestations of bronchogenic carcinoma in elderly persons. It is suggested that these variations represent the effect of different causal mechanisms. The site of 23, or 77 per cent, of the primary lesions was peripheral and of six, or 20 per cent, in the lung root zone. One was too extensive to determine its zone of origin. Twenty of the peripheral lesions were nodular in nature and only three produced atelectasis. Of 27 growths identified histologically, 11 were adenocarcinomas, 11 undifferentiated tumors and only five squamous cell cancers.

The presenting symptom patterns, bronchoscopic results and cytologic studies of the sputum were consistent with the high incidence of peripherally situated neoplasms. Because of the inaccessibility of biopsy material, the diagnosis was established by exploratory thoracotomy in 13 cases and by necropsy in four.

The rapidity of growth and spread of pulmonary cancer in young people is reflected in a number of facts: seven patients had evidences of metastases to the central nervous system when first seen, eight had foci of tumor in peripheral lymph nodes and, although exploration was resorted to in 14 cases, the tumors in only six were resectable. This procedure was curative in no known case. The average duration of life from the onset of symptoms until death was 14 months, but of greater significance in this comparatively small series was the median value of 7.5 months, a mode of four months and the fact that only 25 per cent of the patients lived longer than a year.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

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The Gift of Knowledge

FRANK G. SLAUGHTER, M.D.

"Then, opening their treasures, they offered him gifts." Thus Matthew described the acts of the Wise Men when they found the Infant Jesus. Traditionally each year at Christmas, Christ is reborn in the hearts of those who serve Him, bringing a new hope to the world. Traditionally, too, we bring gifts at this season in His name, to His church and to each other. Today, more than ever before, a precious gift is needed by the world, the gift of wisdom and knowledge dedicated to God that will allow the unbelievable force of the hydrogen nucleus to be harnessed and turned to peaceful pursuits. More truly today than ever in history, mankind stands on the threshold of a true millennium. The forces that can make him free of poverty, hunger, and much of his disease are already known. Only the useful gift of knowledge is needed to provide the key that can unlock this treasure chest and reveal its incalculable riches.

A famous scientist says, "The deuterium (heavy hydrogen) in the ocean's waters is sufficient to provide many times the present rate of world energy consumption for more than a billion years." A single pound of "heavy water," a combination of deuterium and oxygen, can liberate the same amount of energy as half a million pounds of coal, yet costs only $28. Obviously, once a method has been worked out to harness this form of hydrogen for useful purposes, rather than destruction, a nearly unlimited source of power at negligible cost will exist in the waters of the world's oceans. The answer may lie in the mind of a scientist now working in a laboratory, or in the unformed brain of a child yet to be born. What greater gift could possibly be laid at the feet of the Christ Child on this Christmas morning than to dedicate a mind, now or in the future, to this task?

Physicians, more than any other group, understand that no knowledge is either useless or without danger. The poisons that can kill men are also the medicines that cure them. The sword that destroys in battle is fundamentally the same as the scalpel that heals. Even the mind which concerns itself with evil could usually have been turned to good, had the climate of development been favorable. Drugs, anesthetics, even the ma-

chines used in treating human ills, destroy those they serve if used improperly. Dealing with destructive powers as they do every day, physicians can well appreciate the importance of turning them to constructive purposes.

Vocational surveys show that medicine is the most respected of professions among boys and girls in high school. They also show that science is one of the least, although physicians are also scientists. Educators warn that America is falling behind dangerously in the number of scientists our colleges and universities are graduating each year. Industrial plants concerned with atomic and other vital research are begging for scientific minds.

Not all of our own children will be physicians, even if we want them to be. Most of the remainder could become mathematicians, physicists, chemists, members of any one of hundreds of vital fields that make up science today, if we rear them in an intellectual climate that favors the accumulation of knowledge and its dedication to useful purposes. The tremendous influence which this most respected of professions can exert upon the young people with whom doctors come in contact would go a long way toward encouraging the kind of mind which will one day turn the hydrogen atom from a Pandora's box into a treasure house.

At this Christmas season of 1956, let us bring, as our gift to the Christ Child, a new dedication to encourage young people, whether our own children or others, in the study of science. The power to destroy civilization already exists; the power to save it lies in the minds of men of wisdom, using their knowledge in ways taught by Him whose birth we celebrate on December 25.

Editor's Note: The Journal is honored to have for the fourth consecutive year a guest editorial befitting the Christmas Season from the pen of Dr. Frank G. Slaughter, of Jacksonville, Florida's distinguished physician-author.

Cardiac Massage

In all fields of endeavor, be they scientific or otherwise, usage and practice make the exception become commonplace. Such is the history of cardiac massage.

Since 1902, when the first instance of restoration of the normal activity of the human heart by manual means was reported, the importance of the procedure has steadily increased, largely through the efforts of one man, Dr. Claude S. Beck. In the early days of his experimental work in cardiac surgery, he and the late Dr. Elliot C. Carter sought means by which the sufferer from mitral stenosis might obtain relief from the insufficiency caused by the valvular stenosis. Since that time Dr. Beck has striven diligently in the laboratory and operating room to aid those afflicted with inadequate blood supply to the myocardium.

During the half century that followed the first report of successful cardiac massage, 150 reports of attempts to employ this life-saving measure were published. It was not, however, until the early 1950s that organized teaching in the art of resuscitation by cardiac massage was inaugurated by Dr. Beck.

Cardiac arrest is one of the most dreaded complications that can befall any surgical procedure. It can occur in normal, healthy persons who have had no previous signs or symptoms of heart disease. A number of causes may precipitate such a disaster, but the lack of oxygen to the brain actually causes the heart to cease functioning.

From the time the heart stops, the surgeon is allowed a bare five minutes in which to reactivate the flow of oxygenated blood to the brain cells. Otherwise, the patient dies.

The surgeon must be trained to place the patient quickly in a supine position, make an incision between the ribs, and divide the rib cartilages next to the sternum. These preliminary steps should take but a matter of seconds. With the hand in the chest cavity, rhythmic massage of the heart is begun. This procedure may be necessary for as long as 25 minutes or more before the effort is abandoned.

One of the causes of cardiac arrest is ventricular defibrillation, and when this condition is encountered, a defibrillator is applied. This equipment, or some such apparatus that serves the purpose as well, should be in every modern hospital today.

For the past few years, Dr. Beck has been conducting classes in cardiac resuscitation at Lakeside Hospital in Cleveland. As more physicians are trained, the percentage of lives saved by prompt cardiac massage will greatly increase.

National Library of Medicine

A notable event of wide interest to the medical profession was the transfer on October 1 of the Armed Forces Medical Library to the Public Health Service, U. S. Department of Health, Education, and Welfare. At that time the Library was officially turned over to the Public Health Service by Dr. E. H. Cushing, Deputy Assistant Secretary of Health and Medical Affairs, Department of Defense, and was accepted by Dr. Leroy E. Burney, Surgeon General of the Public Health Service.

In accordance with the National Library of Medicine Act, signed by President Eisenhower on August 3 of this year, a National Library of Medicine has been established in the Public Health Service "to assist the advancement of medical and related sciences and to aid the dissemination and exchange of scientific and other information important to the progress of medicine and to public health." The Armed Forces Medical Library now forms the nucleus of the National Library. Its director, Col. Frank B. Rogers, becomes Director of the National Library of Medicine.

Founded in 1836 as the Library of the Surgeon General's Office, U. S. Army, the Armed Forces Medical Library has become one of the largest and most important medical libraries in the world. It contains almost a million volumes, representing literature on medicine, dentistry, pharmacy and allied sciences in all languages and of all times. Its books are loaned to other libraries throughout the United States.

In administering the National Library of Medicine, the Surgeon General of the Public Health Service will be assisted by a Board of Regents consisting of 10 persons to be appointed by the President and confirmed by the Senate. Ex officio members of the Board will be the Surgeons General of the Public Health Service, the Army, Navy and Air Force, the Chief Medical Director of the Department of Medicine and Surgery of the Veterans' Administration, the Assistant Director for Biological and Medical Sciences of the National Science Foundation, and the Librarian of the Congress.

Provision is made in the National Library of Medicine Act for the construction of adequate facilities to house the Library on a site to be selected by the Surgeon General of the Public Health Service at the direction of the Board of Regents. Mr. Robert W. Severance, formerly Librarian of Baylor University, then Deputy Director of the Army Library and more recently on the staff of the Armed Forces Medical Library, will serve as Special Assistant to the Director. He will be wholly concerned with the development of plans for the new building, for liaison work with architect and contractor, for drawing up lists of equipment needs, and for planning and executing the movement of the collections.

Florida physicians are fortunate to have a valuable asset in the large and efficiently managed Library of the State Board of Health in Jacksonville. Mrs. Barbara Beckner, the able librarian, directs attention to the even greater service this library will be in a position to render since it has become a part of the U. S. Public Health Service medical agency which is now centered in the National Library of Medicine. The legislation that established the new library constitutes a much needed forward step for medicine in this country.

Midwinter Seminar in Ophthalmology and Otolaryngology Miami Beach, Jan. 14-19, 1957

The eleventh annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology will convene on January 14 and continue through January 19. As in previous years, Miami Beach will be the host city. All of the meetings will be held at the beautiful new Hotel Seville, and all of its facilities, including the beach and swimming pool, will be available to all registrants of the Seminar and their families. Each winter this meeting attracts physicians from all sections of the United States and from several foreign countries.

On January 14, 15 and 16, the lectures on Ophthalmology will be presented by such distinguished opthalmologists as Dr. Irving H. Leopold of Philadelphia, Dr. Cecil W. Lepard of Detroit, Dr. Francis Heed Adler of Philadelphia, Dr. Algernon B. Reese of New York City, and Dr. Harold W. Brown of New York City.

The lectures on Otolaryngology will be given on January 17, 18 and 19. The eminent otolaryngologists on the program include Dr. Alden H. Miller of Los Angeles, Dr. Porter P. Vinson of Richmond, Va., Dr. Lester Hale of Gainesville, Dr. James B. Costen of St. Louis, and Dr. Philip Meltzer of Boston.

The 1956 Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology will be held on Wednesday afternoon, January 16. All physicians attending the Seminar

are invited to this meeting, held concurrently with the Seminar each year. The featured speaker will be Major General Dan C. Ogle, Surgeon General of the Air Force.

Following the afternoon meeting of the Convention, all Seminar registrants and their wives will be entertained at an informal gathering in the Seville Hotel. At 8 p.m. that night there will be the usual informal dinner which the visiting physicians and their wives may attend.

Graduate Medical Education

Seminar on Cardiovascular Diseases February 21 - 23, 1957

The Northeastern District of the Florida Heart Association, in conjunction with the Division of Postgraduate Education of the College of Medicine of the University of Florida, will present its annual Seminar on Cardiovascular Diseases at the Duval Medical Center in Jacksonville on February 21, 22 and 23. The course is open to all physicians desiring refresher work in cardiology. It also is open to all residents and interns without charge.

Diabetes Seminar Held

The Florida Clinical Diabetes Association, in cooperation with the Florida Medical Association, the Florida State Board of Health, and the Division of Postgraduate Education of the College of Medicine of the University of Florida, presented its fourth annual seminar on diabetes mellitus on October 18 and 19. The total enrolment was 74, and much interest was manifested by those in attendance. The lectures were presented by Dr. Philip K. Bondy, Associate Professor of Medicine at the Yale University School of Medicine, and Dr. Samuel B. Beaser, Clinical Associate in Medicine at the Harvard Medical School. They gave a well balanced program with Dr. Bondy stressing the results of the latest research in diabetes and Dr. Beaser presenting the practical side of the treatment and handling of patients with diabetes mellitus.

The association held its annual meeting, electing Dr. Edward R. Smith, of Jacksonville, President; Dr. George H. Garmany, of Tallahassee, President-Elect; and Dr. Joseph J. Lowenthal, of Jacksonville, Secretary-Treasurer. The membership also voted to change the name of the association to the Florida Diabetes Association. This change along with certain changes in the by-laws and constitution establishes affiliation with the American Diabetes Association. This action leaves the organization in a position to have lay organizations as well as clinical associations affiliated with it.

The next seminar and meeting will be held at the Medical Sciences Building of the College of Medicine of the University of Florida, in Gainesville.

"Medicine and the Law" New Motion Picture Series

The first in a series of motion pictures on "Medicine and the Law" had its premier showing on November 27 at the Clinical Session of the American Medical Association in Seattle. Titled "Doctor, Take the Stand," the 30 minute film discusses the role of the medical expert witness, showing what doctors should do and what they should not do when they testify in court.

Since between 60 and 85 per cent of all court cases involve medical testimony and require physicians as witnesses, the need for educating doctors in courtroom technic is apparent. The "Medicine and the Law" series is being supervised by Joseph Stetler, director of the Law Department of the American Medical Association. "We hope," said Mr. Stetler, "to teach doctors and lawyers how to present cases requiring expert medical testimony thoroughly and accurately so that a just decision can be made." The American Bar Association is cooperating in this law film project.

Produced for the American Medical Association as a service to physicians by the Wm. S. Merrell Co., Cincinnati pharmaceutical house, "Doctor, Take the Stand" will be available after December 15 through the A. M. A. Film Library for use by medical groups. Prints doubtless will be in great demand for the subject should evoke wide interest among physicians generally.

New Radio Series on Medical Progress

A "hit parade" of popular songs and medical innovations across the years, beginning with 1895, is the theme of the American Medical Association's new radio transcription series to be released the end of this month. Entitled "Health and Harmony," this series of 13 programs traces medical progress in five year intervals. The first one, for example, deals with the invention of the x-ray and features such songs as "East Side, West Side" and "Little Annie Rooney." The 1935 contribution is a discussion of the sulfa drugs interspersed with strains of "Red Sails in the Sunset"

and "Zing Went the Strings of My Heart." The story of the development of ACTH and cortisone and such popular songs as "Goodnight, Irene" and "There's No Tomorrow" depict the 1950 era.

Medical information is presented by W. W. Bolton, M.D., and Fred V. Hein, Ph.D., of the Bureau of Health Education of the American Medical Association. A barber shop quartet presents the musical portions. This unique portrayal of progress in medicine during the last 60 years should have wide appeal. The transcriptions will be available to radio stations through the Bureau of Public Relations of the Florida Medical Association in cooperation with the county medical societies as are other programs on health subjects.

Southern Medical Association Golden Anniversary Meeting Held

The Fiftieth Annual Meeting of the Southern Medical Association, held at the Sheraton-Park Hotel in Washington in mid-November, attracted many Floridians. A large number of Florida physicians made noteworthy contributions to the scientific program, presenting and discussing papers and taking part in panel discussions and symposiums. More than 300 papers were presented during the scientific assembly, which includes 20 specialty sections.

Some 5,000 visitors converged on the nation's Capital for this Golden Anniversary meeting of the second largest general medical organization in the United States. In addition to the wide variety of professional activities, the many other attractions of the four day gathering included official tours of Washington and vicinity, including the city's unexcelled medical facilities, a performance by Washington Doctors' Symphony Orchestra, a golf tournament, and scores of special breakfasts, luncheons, dinners, alumni and fraternity reunions, and Woman's Auxiliary functions. The opening day was designated "D. C. Day," and throughout the meeting the members of the Medical Society of the District of Columbia proved themselves most gracious and experienced hosts for this gala occasion.

A large representation of Florida physicians participated in the program during this historic meeting. Those presenting papers in the various sections and their subjects were: Dr. Clarence Bernstein and Dr. S. D. Klotz, of Orlando, "Allergy to Meprobamate with Some Observations Regarding the Tranquilizing Drugs;" Dr. John T. Stage, of Jacksonville, "Illustrated Electrolyte and Fluid Balance;" Dr. Morris Waisman, of Tampa, "Cutaneous Papillomas of the Neck: Papillomatous Seborrheic Keratoses;" Dr. B. E. Lowenstein, of South Miami, "The Diabetic's Best Friend;" Dr. James Henry Ferguson and Dr. Harvey Lozman, of Miami, "Experiences with Vaginal Cytology at the Jackson Memorial Hospital, Miami;" Dr. Ulfar Jonsson, Dr. John W. Frost and Dr. Ralph Jones, of Miami, "The Treatment of Polycythemia Vera with Pyrimethamine (Daraprim);" Dr. Rex M. Bleakney, of Orlando, "Intracranial Aneurysms Complicating Pregnancy;" Dr. Abraham R. Hollander, of Miami Beach, "Newer Concepts Concerning the Preventive Influence of Tonsillo-Adenoidectomy on the Common Cold in Children;" Dr. W. A. D. Anderson, of Miami, "Recent Problems in the Practice of Pathology;" Dr. Milton S. Saslaw, of Miami, "The Hereditary Factor in Rheumatic Fever in Florida;" Dr. Matthew A. Larken, of Miami, "Benign Tumors of the Rectum, Potentially Malignant;" and Dr. Russell B. Carson, Dr. W. Dotson Wells and Dr. John I. Williams, of Fort Lauderdale, "Reflux Ureteropylograms in Children."

In addition, three Florida physicians, each serving as chairman of a section during 1956, presented a chairman's address. Dr. John M. Rumball, of Coral Gables, chairman of the Section on Gastroenterology, chose for his subject "Serum Iron Content in Gastrointestinal Disturbances." The chairman of the Section on Radiology, Dr. Charles M. Gray, of Tampa, spoke on "A Task for Tomorrow." The subject of the address of Dr. Milton M. Coplan, of Miami, chairman of the Section on Urology, was "The Perineal Testis." Dr. Sherman B. Forbes, of Tampa, was elevated to the chairmanship of the Section on Ophthalmology and Otolaryngology for 1957.

Among the many doctors from Florida who discussed papers or participated in seminars were Dr. Morris Waisman, of Tampa; Dr. Joseph A. J. Farrington, of Jacksonville; Dr. Wesley W. Wilson, of Tampa; Dr. Chester Cassel, of Miami; Dr. Walter W. Sackett Jr., of Miami; Dr. Charles J. Collins, of Orlando; Dr. James H. Ferguson, of Miami; Dr. Thomas E. Scott Jr., of Daytona Beach; Dr. Charles Stansky, of Bay Pines; Dr. Robert N. Webster, of Tallahassee; Dr. Perry D. Melvin, of Miami, and Dr. Robert B. McIver, of Jacksonville.

The special Symposium on Geriatrics, initiated most successfully at the Houston meeting last year, was presented again this year as a popular

feature. Taking part in this Symposium was Dr. Joseph S. Stewart, of Miami, whose subject was "What Is Being Done in Southern States."

General Practitioners Annual Scientific Assembly Held

Dr. Alton Ochsner of New Orleans was the featured speaker at the Seventh Annual Scientific Assembly of the Florida Academy of General Practice, held at the Hotel Roosevelt in Jacksonville on October 20 and 21. At the opening session on Saturday morning this internationally known surgeon, who heads the Department of Surgery at Tulane University School of Medicine, presented a scientific paper on "Management of Ulcerations of the Stomach and Duodenum." At the banquet that night, speaking on "The Influence of Serendipity on Medicine," he cited numerous instances in which scientists have made important discoveries they were not looking for in conducting their experiments in pursuit of other goals and predicted that physicians who take time to observe intelligently and carefully evaluate what they see from day to day will continue to make discoveries of great value.

The afternoon session on Saturday was devoted to a round table discussion of "Emotional Problems in General Practice." Among the distinguished participants was Dr. H. Keith Fischer, eminent Philadelphia psychiatrist, who pointed out that the doctor's role in guiding young people is primarily to point out the necessity of rational discussion of their problems.

The entire program for the second day of the two day conference consisted of a Symposium on Automobile Safety. The various aspects of this timely subject were ably presented by well qualified medical and lay speakers. On the preceding afternoon there was a television presentation over WJHP-TV on "Medicine's Role in Injury and Accident Prevention," moderated by Mr. John D. Moore, Director, Automobile Crash Injury Research, Cornell University Medical College.

OTHERS ARE SAYING

"As The Twig Is Bent"

Several weeks back, the Dads' Club of one of the local grammar schools was entertained with a drill performed by their School Boy Patrol. This group was composed of students in the 6th grade and selected from volunteers by their teachers with the approval of the principal and the boys' parents. As I sat and watched, I was overcome with emotion and admiration. As I sat and listened to each member report and give their by-laws, I wondered what the years would do to each one and what might be their life work. Would they become policemen, teachers, doctors or law breakers? Surely, here was being taught a firm foundation in character developing traits. Here was a practical approach to teaching obedience to proper authorities, discipline to one's self and protection of the safety and rights of others.

Sometimes, however, when I am stopped at a school zone in my morning dash to the hospital, I can sympathize with Paul Gallico who in a recent periodical wrote about the "little Copper." On a trip to Miami, he was stopped at a crossing by a schoolboy patrolman. His anger was aroused by the "exasperating arrogance with which the brat was stopping cars and then waving them on when he got good and ready." He blamed for this not the boy but the parties who furnished the boy with the equipment and the responsibility.

Honestly, I can't agree with Mr. Gallico. Giving a boy a feather headdress doesn't bestow on him the character of the redman, and neither does pinning a badge on his shirt make him arrogant. I wish that Mr. G. had been sitting with me that night to watch the patrol drill. One of its members was the son of a neighbor. This boy visits my home and at these times he has always appeared courteous, respectful and mindful of the property of others. Another patrolboy was the son of a member of this society. In his bearing and his speech, he was soldierly. He did not appear overbearing, and I couldn't imagine him showing arrogance. No, Mr. Gallico, what those boys are and how they might act are not because of the badge they wear or the flag they hold in their hands. They are courteous, kind, and obedient; first, because of the home training they have received and the examples set by their parents. Secondly, these traits are encouraged and strengthened by serving in the School Boy Patrol.

I might grumble but I'll stop whenever they signal to me. It might be one of my children for whom they're holding up traffic.

C. M. C.

—*Monthly Bulletin,*
Duval County Medical Society
August, 1956

CLASSIFIED

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

MEDICAL OFFICE FOR LEASE: New Medical-Dental Arts Building. Air conditioned. Large waiting rooms. Very reasonable lease for the right medical doctors. Write H. W. Tustison, D.D.S., 1000 S. Federal Highway, Fort Lauderdale, Fla.

WANTED: Physician with Florida license. Interest in Physical Medicine and Geriatrics. State qualifications in writing. The Miami-Battle Creek, Miami Springs, Fla.

PHYSICIAN WANTED: Two General Practitioners, Pediatrician, E.E.N.T. (Board Member), and Psychiatrist to associate with a well established medical group in a rapidly growing central Florida East Coast area. Salary Open — depending on experience and training—with eventual partnership. Give complete personal and professional data in first letter. Florida license required. Write P.O. Box 57, Rockledge, Fla.

FOR SALE: New 14 bed Nursing Home well equipped also beautiful new residence both in 10 acre orange grove. Nursing home easily adaptable for doctors practice. Shown by appointment. Apply Box 47, San Antonio, Fla.

WANTED: Internist, Pediatrician or General Practitioner to fill vacancy in South Central Florida in association with surgeon. Unusual opportunity to get quickly established without great expense. Write for appointment for interview. Write 69-197, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER: Excellent opportunity in Orange City. Approximately 6000 population in area not served by a doctor. Finest living conditions in fast growing Central Florida. Write for information. Harry F. Edwards, Box 708, Orange City.

FOR SALE OR LEASE: Physician's office with good practice. Long established in growing Florida East Coast city. Prefer Southerner interested in general practice. Wonderful opportunity. Write 69-200, P.O. Box 2411, Jacksonville, Fla.

INTERNIST: Board qualified. Desires association with Internist or group. Age 30. Married. Military obligations completed. Florida resident. Available for interview. Write 69-204, P. O. Box 2411, Jacksonville, Fla.

FOR RENT: Office space in St. Petersburg. Centrally located. Spacious enough for two physicians—six rooms and two baths. Ten year lease if desired. Contact: Mrs. Thelma Moss, 354 Fourth St., N., St. Petersburg, Fla.

PHYSICIAN WANTED IMMEDIATELY: General practice in small town. Practice now established. Unusual opportunities for any doctor. Reasonable rents. Small, efficient hospital. Contact Mayor Gene Bailey, Williston, Fla.

INTERNIST: Age 30. Married. Finish formal training March 1957. Category IV. Florida license. Interested in promising location or association. Write 69-205, P.O. Box 2411, Jacksonville, Fla.

COMPONENT SOCIETY NOTES

Alachua

The Alachua County Medical Society has paid 100 per cent of its state dues for 1956.

Brevard

The Brevard County Medical Society held its October meeting in the Daniel Memorial Hospital at Titusville with Dr. Isabel Roberts, of Melbourne, president, presiding. Following the meeting, a tour of the new hospital was conducted for members of the Society.

Broward

Dr. John D. Milton, of Miami, immediate past president of the Florida Medical Association, and Dr. John J. Farrell, Professor of Surgery at the University of Miami School of Medicine, were guest speakers for the September meeting of the Broward County Medical Association.

Dr. Milton discussed the proposed program for medical care for dependents of the uniformed services in Florida. Dr. Farrell's address was entitled "Fluid and Electrolyte Balance."

Dr. David S. Howell, Assistant Professor of Medicine at the University of Miami School of Medicine, was speaker for the October meeting. His subject was "Cortisone and Similar Products, Their Uses and Abuses."

Duval

Dr. L. D. Pankey, of Coral Gables, was principal speaker for the November meeting of the Duval County Medical Society. The title of his address was "Investments for the Professional Man."

Leon-Gadsden-Liberty-Wakulla-Jefferson

The Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society has paid 100 per cent of its state dues for 1956.

Pinellas and Hillsborough

The Pinellas County Medical Society and the Hillsborough County Medical Association held their joint meeting November 5 in the Fort Harrison Hotel at Clearwater. Guest speaker was Dr. Frederick C. Irving, Professor Emeritus of Obstetrics, The Harvard University Medical School. Dr. Irving's subject was "Changes in Medical Education in 40 Years."

Putnam

The Putnam County Medical Society has paid 100 per cent of its state dues for 1956.

STATE NEWS ITEMS

Dr. Hewitt Johnston of Orlando and Dr. Henry O. Heath of Pensacola have been honored by the University of Tennessee Medical Units for "their half century of service to their fellow man." Both Dr. Johnston and Dr. Heath were awarded the Golden "T" Certificate.

Drs. Raymond J. Fitzpatrick and Albert G. Love IV of Gainesville have returned from Chicago where they attended the meetings of the International College of Surgeons.

Dr. Frank G. Slaughter of Jacksonville was principal speaker for special Rally Day services held recently at the Riverside Park Methodist Church School in the city.

Dr. Hawley H. Seiler of Tampa served as guest moderator at the recent District I Sanatorium Chest Conference held at Decatur, Ala. In addition to acting as moderator, Dr. Seiler discussed surgical diseases of the esophagus and presented an exhibit dealing with variable forms of bronchogenic carcinoma.

Dr. Rothwell C. Polk of Jacksonville has been elected a Fellow of the American College of Surgeons.

Dr. Peritz Scheinberg of Miami, Associate Professor of Neurology at the University of Miami School of Medicine, was guest speaker on the panel which discussed "Cerebrovascular Accidents: Diagnosis and Modern Treatment" at the 5th Inter-American Congress of Cardiology held November 11-17 at Havana, Cuba. Dr. Scheinberg also presented a paper entitled "The Differential Diagnosis of Vertigo" at the regional meeting of the American College of Physicians held the latter part of October in Nassau.

Dr. Alvan G. Foraker of Jacksonville presented a paper entitled "'Nuclear Mass of Endometrial Cells in the Normal Menstrual Cycle" at the International Cancer Cytology in Chicago the early part of October.

Drs. Samuel T. Register of Clearwater, Sherman B. Forbes of Tampa and G. Dekle Taylor of Jacksonville were among members of the Florida Medical Association attending the meetings of the American Academy of Ophthalmology and Otolaryngology held in Chicago.

Dr. Benjamin F. Barnes of Chattahoochee has been presented a service pin by the Gadsden County Chapter of the American Red Cross in recognition of his 25 years' service to the Chapter.

Dr. John E. Maines of Gainesville has returned from San Francisco where he attended the annual meeting of the American College of Surgeons.

Dr. Alma Trappolini of Miami has been selected as "Woman of Achievement for 1956" by District 10 of the Business and Professional Women's Clubs.

Release of a new book compiled and edited by Dr. Arthur J. Butt of Pensacola has been announced by the publishing firm of Charles C. Thomas. Entitled "Etiologic Factors in Renal Lithiasis," the monograph contains several sections written by Dr. Butt.

Dr. Hugh H. Barfield of Ocala was featured speaker at the recent meeting of the Sumter County Unit of the American Cancer Society held at Bushnell.

Dr. Horace M. Anderson of Jacksonville has been selected as chairman of the Doctors' Division for the Community Chest-United Fund campaign in the area.

Dr. Myron L. Habegger of Rockledge was principal speaker at a recent meeting of the Kiwanis Club of Cocoa. His subject was tuberculosis.

Mediclinics second annual postgraduate refresher course will be held in Fort Lauderdale, March 4-14, 1957, sponsored by the Florida Academy of General Practice. The course is certified for 32 hours of credit by the American Academy of General Practice.

Consisting of lectures and panels by a prominent faculty, the course features varied subjects in the several fields of medicine. The program also includes seven optional luncheon meetings.

Registration is limited to 300. The tuition fee is $50 payable in advance to Mediclinics of Minnesota, 516 Medical Arts Bldg., Minneapolis 2, Minn.

Dr. William H. McCullagh of Jacksonville has been elected president of the Southern Psychiatric Association.

Dr. Gail M. Osterhout of Inverness appeared on the program "Teaching Children Health Habits in the Home" sponsored by the local Parent-Teachers Association as its topic for the September meeting.

Opening to patients of the 50 bed specialized hospital of the Florida Alcoholic Rehabilitation Program located at Avon Park has been postponed due to difficulties in obtaining equipment. Previously it had been announced that the hospital would be open "before January, 1957."

Dr. Leonard L. Weil of Miami Beach has been elected president of the Dade County Chapter of the American Academy of General Practice. Other new officers are Dr. Robert C. Piper, vice president, and Dr. Jack Keefe, secretary-treasurer. Dr. Vincent P. Corso was elected to the board of directors.

Dr. Francis H. Langley of St. Petersburg, president of the Florida Medical Association, was guest speaker for a recent meeting of the Woman's Auxiliary to the Pinellas County Medical Society held at St. Petersburg. The title of Dr. Langley's address was "Progress in the Science and Art of Medicine."

Dr. Ralph B. Hanahan of Lakeland has been chosen medical vice president of the Polk County Cancer Society. Dr. Chester L. Nayfield, also of Lakeland, will serve the group as public health officer.

Drs. Hugh B. Haston Jr., Charles A. Mead Jr., Bernard L. N. Morgan, William W. Waring and Richard A. Worsham, all of Jacksonville, gave brief addresses at a recent meeting of the Lake City Rotary Club. The physicians were introduced by Dr. Thomas H. Bates of Lake City.

Dr. George T. F. Rahilly of Fort Lauderdale has returned from San Francisco where he attended the meeting of the American College of Surgeons.

Drs. George H. McSwain and Herbert A. King of Daytona Beach and Dr. Ashbel C. Williams of Jacksonville appeared on the program of the regional cancer seminar held at Daytona Beach early in October.

Dr. Turner Z. Cason of Jacksonville has returned from Nassau where he attended the meetings of the American College of Physicians.

Dr. M. Crego Smith of Clearwater attended the World Medical Association meeting in Havana, Cuba, October 9-15.

Dr. Samuel G. Hibbs of Tampa, Dr. Terry Bird of Sanford, Dr. W. Tracy Haverfield of Miami, Dr. John T. Benbow of Chattahoochee, and Drs. Edward Jelks, Sullivan G. Bedell, Wilson T. Sowder and Albert V. Hardy all of Jacksonville were among members of the Florida Medical Association who attended the Mental Health Conference held the last of October in Jacksonville.

Dr. Bedell, chairman of the Committee on Mental Health of the Florida Medical Association, was presiding officer for the Conference. It was sponsored by the Association, the Florida Mental Health Association and the Florida State Board of Health. Keynote speaker was Dr. William G. Hollister, consultant in mental health education, National Institutes of Health, Bethesda, Md.

Dr. John C. Ajac of Miami was one of the principal speakers at the recent meeting of the Florida State Nurses Association held in Fort Lauderdale. The subject of his address was "Cobalt Therapy."

The Council on Postgraduate Medical Education of the American College of Chest Physicians will present three postgraduate courses on "Diseases of the Chest" during the period January-April, 1957. The courses are to be held at Vanderbilt University, Nashville, Tenn., Jan. 14-18; Mark Hopkins Hotel, San Francisco, Feb. 25-March 1; Bellevue-Stratford Hotel, Philadelphia, Penn., April 1-5. Tuition for each course is $75.

The Mid-Winter Meeting of the Florida Obstetric and Gynecological Society was held December 1-2 in Nassau at the Fort Montagu Beach Hotel.

Dr. F. Bayard Carter, Professor of Obstetrics and Gynecology at Duke University School of

Medicine, Durham, N. C., and Dr. John Parks, Professor of Obstetrics and Gynecology at Georgetown University School of Medicine, Washington, D. C., were guest speakers. On the opening day, they discussed "Uterine Obstetric Hemorrhage" and the following day "Indications for Hysterectomy." A discussion period followed the presentation of each subject.

Dr. S. L. Watson of Lakeland served as president of the Society for the past year. He was succeeded at the meeting by Dr. S. Carnes Harvard of Brooksville who was chosen president-elect at the last meeting. Dr. T. Bert Fletcher Jr. of Tallahassee is secretary-treasurer.

The Seventh International Cancer Congress will be held in London July 6-12, 1958, under the Presidency of Sir Stafford Cade. There will be two main sessions of the Congress: Experimental, and Clinical and Cancer Control. Special emphasis will be placed on hormones and cancer, chemotherapy, carcinogenesis and cancer of the lung.

Proffered papers will only be considered if submitted with an abstract of not over 200 words before October, 1957, and if dealing with new and unpublished work.

Registration forms and a preliminary program will be available early in 1957 on application to The Secretary General, Seventh International Cancer Congress, 45 Lincoln's Inn Fields, London, W.C. 2, England.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Deen, Duane C., Winter Park
Dippy, Theodore A., Winter Park
Hallstrand, David E., South Miami
Hallstrand, Harold O., South Miami
Grier, Arnold, Miami Beach
Kane, Arnold L., Miami
McCook, Walter R., Key West
Meares, Edward F., Orlando
Merkin, Alvin, Miami Beach
Noyes, Charles E., Orlando
Ogden, Alfred E., Miami
Peppercorn, Bert L., Miami Beach
Pinks, David K., Miami Beach
Reilly, Carl N., Winter Haven
Samet, Philip, Miami Beach
White, Bradford C., Orlando

Medical Licenses Granted

Dr. Homer L. Pearson Jr., Secretary of the State Board of Medical Examiners, has reported that of the 409 applicants who took the examination of the Board, held June 25 and 26, 1956, in Miami Beach, 322 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 322 successful applicants follow:

Abelove, William Alvin, Miami (Jefferson 1951)
Adelizzi, Dante Louis, Boston (K.C. U. P&S 1943)
Adler, Sidney, Miami (U. Miami 1956)
Agner, Roy Augusta Jr., Salisbury, N. C. (Duke 1951)
Aker, Charles Mack, Wabasso (U. Tenn. 1945)
Aldrich, Ellerton Gordon, Sarasota (U. Mich. 1930)
Allee, James William, Columbia, Mo. (Washington U. 1932)
Allen, Herbert Lewis, Bamberg, S. C. (M.C. of S.C. 1952)
Alper, Richard Gerald, Miami Beach (U. Miami 1956)
Araj, Jacob Saba, Sheppard A.F.B., Tex. (Beirut 1947)
Askowitz, Leonard Allan, Miami Beach (U. Tenn. 1956)
Axilrod, Herbert David, Atlantic City, N. J. (Johns Hopkins 1944)

Bacon, John Donnell, York, Pa. (U. Penn. 1951)
Baggett, Arthur Edward Jr., Titusville (Tulane 1955)
Bailey, Bill Martin, Lakeland (M.C. of Ga. 1955)
Beamer, William Dale, Lantana (Jefferson 1937)
Beasley, Frank Johnson, Danville, Pa. (Jefferson 1954)
Beckner, Thornton Arnold, Jacksonville (Med. Evang. 1955)
Belcher, Rodney Lynn, Washington, D.C. (U. Miami 1956)
Bendeck, Taufick Elias, Roosevelt, P. R. (Harvard 1949)
Bengtson, John Willard, Rocky Hill, Conn. (U. Rochester 1948)
Berg, George Shepard, Miami Beach (New York U. 1948)
Berger, Allan Sidney, Branford, Conn. (State U. New York 1955)
Bersani, Frank Anthony, Syracuse, New York (Syracuse U. 1949)
Blalock, John Corbett Jr., Atlanta, Ga. (Emory 1956)
Blalock, Shatteen Taylor, (f), Atlanta, Ga. (Emory 1956)
Blank, Harvey, Coral Gables (U. Chicago 1942)
Blank, Richard Harrod, Tampa (Cornell 1953)
Blevins, Justin Cline, Miami (U. Tenn. 1955)
Bloomer, William Earl, Decatur, Ga. (U. Va. 1945)
Boese, Robert Rudolph, Fort Lauderdale (Tulane 1951)
Boggess, Shelby Francis II, Miami (U. Louisville 1955)
Bohn, Richard Henry, Coral Gables (Baylor 1950)
Bossard, John Wesley, Rochester, Minn. (U. Maryland 1951)
Bourland, William Lee, Winter Garden (Duke 1955)
Braverman, Leo, Miami (U. Miami 1956)
Brendze, Robert Baker, Chelsea, Mass. (S. W. Tex. MC 1949)
Brennan, Robert Joseph, Fort Lauderdale (U. Illinois 1942)
Britsch, William Philip, Miami (Hahnemann 1941)
Brown, Willis Alston III, Tampa (U. Miami 1956)
Burke, Henry Francis, Gainesville (Boston U. 1948)
Bussey, Joe Leverett, Pompano Beach (Emory 1954)
Butscher, William Charles Jr., Ocala (Jefferson 1944)

Calef, Bension, Farmington, Conn. (St. Louis U. 1932)
Cameron, Donald Franklin, Wilmington, Del. (Hahnemann 1952)
Campbell, Richard Kennon, Miami (Tulane 1956)
Cannon, Curtis Wilfred, Jacksonville (U. Miami 1956)
Canton, John Norman, St. Petersburg (U. Tenn. 1955)
Carr, George Lafayette, Atlanta, Ga. (George Washington 1952)
Carter, Thomas William Jr., Winter Park (U. Illinois 1951)
Cavell, Gordon Frank, Richmond, Va. (W. Ontar. 1950)

Ciriacy, Edward Walter, Ely, Minn. (Temple 1952)
Clarke, William Parker, Jacksonville (U. Tenn. 1956)
Cleveland, William West, Miami (Vanderbilt 1950)
Collette, John Walton, Crescent City (Emory 1956)
Collins, Herbert Warren, Orlando (U. Tenn. 1950)
Conners, James Joseph, Nashville, Tenn. (Vanderbilt 1948)
Cook, Thomas Darwin, Fort Bragg, N. C. (Yale 1943)
Covell, William Arnold, DeFuniak Springs (Bowman Gray 1955)
Cox, David John Jr., Winter Haven (St. Louis U. 1949)

Dailey, James Omar, Memphis, Tenn. (U. Miami 1956)
Davis, Albert James Jr., Louisville, Ky. (M.C. Va.)
Davis, Edwin Dyer, Philadelphia (Jefferson 1953)
Davis, Hugh James, Thorsby, Ala. (Johns Hopkins 1953)
Davis, Janis Gover, Louisville, Ky. (Georgia 1950)
Deen, Duane Conley, Orlando (U. Pittsburgh 1952)
Dellinger, Ray Eugene, Atlanta, Ga., (Emory 1955)
Demick, Paul Edward, Miami (U. Vt. 1955)
De Padua, Virgilio Barona, Anniston, Ala. (U. Philippines 1945)
Dillard, Richard Augustus, Birmingham, Ala. (U. Penn. 1948)
Dippy, Roy Henry, Orlando (Emory 1956)
Doucette, Jack Walter, Miami (U. Mich. 1955)
Dozier, Laurie Lester Jr., Tallahassee (Duke 1956)
Draper, Arthur Derby Jr., Tampa (Emory 1956)
Dukes, Thomas Earle Jr., Orlando (Emory 1956)
Dussia, Evan Earl, Tallahassee (Wayne U. 1948)

Eaddy, Joseph Albert, Bushnell (Emory 1956)
Echevarria, Emilio Daniel, Tampa (U. Miami 1956)
Edwards, Harry Alfred Jr., Nashville (Vanderbilt 1956)
Emerson, John Adams, Delray Beach (New York MC 1956)
Ersay, Emil Francis, Cleveland (U. Buffalo 1933)
Ettinger, James William, Jacksonville (U. Tenn. 1955)
Everitt, Kathleen, Atlanta, Ga. (U. Miami 1956)

Favata, John Joseph, Miami (U. Miami 1956)
Fields, Jerome, Coral Gables (Hahnemann 1955)
Fierer, Eugene Mark, Miami Beach (Chicago 1952)
Fine, Seymour Harold, Mamaroneck, N. Y. (New York 1938)
Forlaw, James Russell, Jacksonville (U. Miami 1956)
Freedman, Robert, Stamford, Conn. (New York MC 1945)
Friedman, Marcia Laura Gordon, Miami (Harvard 1949)
Fromhagen, Carl Jr., Miami (Emory 1955)
Funderburk, Eugene Emerson Jr., Philadelphia (Bowman Gray 1953)

Glover, Nathan, Miami (U. Vt. 1952)
Goldberg, Jack Leon, Columbus, Ohio (Ohio St. U. 1956)
Goldstein, Edward Stanley, Jamaica, N. Y. (Albany 1953)
Good, Raphael Simeon, Chanute, Ill. (U. Buffalo 1948)
Goodless, Maxwell David, Hollywood (U. Toronto 1950)
Graf, George Paul, Rochester, Minn. (U. Wis. 1950)
Graham, Edward Wendell, (Col.), Miami (Meharry 1955)
Greco, William Richard, Baltimore (U. Maryland 1952)
Greenwood, Robert Walton, Drexel Hill, Pa. (Cornell 1950)
Griffeth, Joe Leonard, Macon, Ga. (Georgia 1956)
Griffin, John Bunyan Jr., Atlanta, Ga. (Emory 1956)

Haley, Raymond Carter Jr., Orlando (Emory 1953)
Hall, Marshall Frederick, Miami (Indiana U. 1954)
Hamilton, John McFarland, Sarasota (La. State U. 1949)
Hance, Darwood Blaise, Miami (U. Tenn. 1956)
Hardwick, Charles William, Slocomb, Ala. (Alabama 1956)
Harris, Stephen Martin, Coral Gables (Boston 1951)
Harvey, Alexander Thom, Omaha (U. Nebr. 1950)
Hays, Glenn Bare, Bartow (Bowman Gray 1950)
Hassler, William Lada, Cleveland (Duke 1956)
Hazlehurst, George Nicholls, Miami (Columbia U. 1947)
Hebert, Eric Paul, New Orleans (La. State U. 1955)
Hellinger, Frank Rudolph, Jacksonville (Northwestern 1955)
Hendricks, Charles Marvin Jr., Portsmouth, Va. (South Carolina 1948)
Herreid, Ernest Oliver Jr., Miami (U. Vt. 1955)
Hill, Carl William, San Pedro, Calif. (U. Toronto 1947)
Hillman, Milton, Miami Beach (U. Miami 1956)
Hills, Arthur Gorman, Miami (Johns Hopkins 1942)
Hixon, Marvin Allen, Naples (Tulane 1956)
Hollander, Asher, McKeesport, Pa. (U. Maryland 1941)
Hollingsworth, Gerald Martin, Jacksonville (Harvard 1955)
Hood, Claude Ian, Gainesville (Liverpool 1948)
Hoover, George William, Fort Lauderdale (George Washington 1944)
Houston, Jack Maurice, Miami Beach (Northwestern 1924)
Howerton, James Robert, Charlotte N. C. (U. Tenn. 1955)
Hudgens, John Clark Jr., Long Beach, Miss. (Tulane 1955)
Hunter, William Armstrong Jr., Gainesville (Vanderbilt 1956)
Hutchin, Peter, Durham, N. C. (Duke 1956)

Jackson, John Davies, New Orleans (Tulane 1952)
Jensen, Leif George, Staten Island, N. Y. (Cornell 1923)
Joel, Robert Vinacoeur, Miami (Chicago 1956)
Joest, Charles Orion, Jacksonville (Indiana U. 1943)
Johnson, John Thomas, Miami (U. Louisville 1955)
Johnson, William Douglas, Hollywood (U. Penn. 1953)
Jones, Bruce Leigh, Clinton, N. C. (Columbia 1913)
Jones, Harris Quillian Jr., Fort Myers (Emory 1956)
Jones, Ralph Jr., Miami (U. Penn. 1943)

Kalas, John Peter, Daytona Beach (Temple 1956)
Kaplan, A. N. Jr., Miami (Bowman Gray 1956)
Keen, Ralph, Jamaica, N. Y. (New York MC 1944)
Kenaston, Thomas Corwin Jr., Cocoa (Duke 1954)
Kenyon, Norman Maurice, Memphis, Tenn. (U. Miami 1956)
Kiehl, Kenneth Calvert, Tampa (U. Miami 1956)

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SEARLE

Kilgore, Samuel Rea, Coral Gables (Duke 1943)
Killinger, William Allen, Dallas, Tex. (Tulane 1956)
Kimmel, Bernard, Royal Oak, Mich. (U. Mich. 1956)
Klein, Melvin, Miami (U. Zurich 1954)
Koger, Edward Richard, Hialeah (Duke 1956)
Kramer, David, Miami (U. Tenn. 1956)
Kramer, Harold Coleman, Baltimore (U. Maryland 1956)
Krans, DeHart, Tallahassee (Cornell 1936)
Kreider, Everette Francis Jr., New Orleans (Baylor 1951)
Krueger, John Jay, Jacksonville (Virginia 1956)
Kurzweg, Frank Turner, Miami (Harvard 1942)

Lane, David Campbell, Madison, Wis. (U. Tenn. 1951)
Lang, Frank Alexander Jr., Fort Lauderdale (Duke 1956)
Langley, Warren Franklin, Natick, Mass. (Boston 1951)
Laszlo, Maurice Harold, Miami Beach (Chicago 1952)
Levin, Burton David, Chicago (U. Illinois 1947)
Lewis, Gordon Foster, Coral Gables (U. Miami 1956)
Liberman, Milton Jack, Lafayette, La. (La. State U. 1952)
Lieber, Hyman, Miami Beach (N. Y. MC 1930)
Litwak, Robert Seymour, Miami (Hahnemann 1949)
LoPopolo, Vincent Charles, Philadelphia (Boston P&S 1947)
Lucas, Roy Hilty, Winter Haven (Cornell 1952)

MacLean, J. Arthur Jr., Coral Gables (U. Mich. 1932)
Magee, William Edwin, St. Louis (Duke 1950)
Magruder, George Brock, Orlando (Emory 1956)
Mahoney, Jack Lawrence, Rochester, Minn. (Jefferson 1952)
Major, James Calder, Atlanta, Ga. (Emory 1956)
Malone, Randolph Augustus III, Coral Gables (Emory 1956)
Martin, Cornelia Ruth Campbell, Gainesville (Washington U. 1941)
Martin, Laurette Adelaide (f), Miami (Women's MC Pa. 1955
Martin, Samuel Preston, Gainesville (Washington U. 1941)
Mazaleski, Edward Bernard, Pittsburgh (Georgetown 1954)
McDaniel, Grover Cleveland Jr., Shelby, N. C. (Bowman Gray)
McEuen, Marianne Borkey, Jacksonville (Temple 1956)
McKay, John Warren, Rochester, Minn. (U. Kansas 1950)
McKechnie, Franklin Bowman, Miami (Johns Hopkins 1945)
McKell, Joseph Power, Tampa (Tulane 1952)
McShane, William James, Coral Gables (U. Penn. 1955)
Meyer, William Henry Jr., North Miami (Albany 1955)
Meyerson, Sheldon Barnett, North Miami (Jefferson 1956)
Mickler, Frederick Troupe Jr., Madison (Emory 1956)
Middleton, Milton Green, Jacksonville (Georgia 1955)
Miller, Abraham Herbert, Miami Beach (U. Penn. 1954)
Miller, Helen Koelsch, Tampa (Marquette 1948)
Mitchell, Stanley D., Miami Beach (U. Tenn. 1956)
Monash, Samuel, Miami Beach (Columbia 1925)
Moore, Milton Brittain Jr., Jacksonville (Emory 1956)
Mora, Modesto Mario, Miami (Havana 1949)
Moran, James Dignan, New Orleans (Emory 1954)
Morrow, Robert Earl, Miami (Jefferson 1955)
Mulford, William Aaron, Daytona Beach (U. Iowa 1951)
Mullen, Warren Robinson, Pentwater, Mich. (U. Mich. 1952)
Munroe, Colin Alexander, Durham, N. C. (Duke 1939)
Murphy, William Henry, Rockville Centre, N. Y. (Long Island 1944)

Nass, William Hans, Pensacola (New York 1956)
Neale, Richard Carroll, Tampa (Virginia 1936)
Nelson, Arthur Ryden, Ashtabula, Ohio (Johns Hopkins 1949)
Nelson, Harold Stanley, Miami (Emory 1955)

Overby, Harry Thomas, Miami (U. Cinn. 1950)

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THE NEW ORLEANS GRADUATE MEDICAL ASSEMBLY

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Nelson Paul Anderson, M.D., Los Angeles, Calif. Dermatology
J. Edward Berk, M.D., Detroit, Mich. Gastroenterology
Erle Henriksen, M.D., Los Angeles, Calif. Gynecology
Ovid O. Meyer, M.D., Madison, Wis. Internal Medicine
Irvine H. Page, M.D., Cleveland, Ohio Internal Medicine
Barnes Woodhall, M.D. Durham, N. C. Neurosurgery
John E. Savage, M.D., Baltimore, Md. Obstetrics
C. Dwight Townes, M.D., Louisville, Ky. Ophthalmology
Don King, M.D., San Francisco, Calif. Orthopedic Surgery
Glassell S. Fitz-Hugh, M.D., Charlottesville, Va. Otolaryngology
Malcolm B. Dockerty, M.D., Rochester, Minn. Pathology
Sydney S. Gellis, M.D., Boston, Mass. Pediatrics
Karl Zimmerman, M.D., Pittsburgh, Penna. Proctology
Laurence L. Robbins, M.D., Boston, Mass. Radiology
Danely P. Slaughter, M.D., Chicago, Ill. Surgery
C. Stuart Welch, M.D., Albany, N. Y. Surgery
William L. Valk, M.D., Kansas City, Kan. Urology

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For information concerning the Assembly meeting and the tour write Secretary, Room 103, 1430 Tulane Avenue, New Orleans 12, La.

Padilla, Jose Bonifacio, Miami (Havana 1949)
Panos, Theodore Gus, Jacksonville (Emory 1956)
Parvey, Arthur Irving, Columbia, S. C. (Tufts 1944)
Pearl, Arthur Jay, Miami (Emory 1956)
Pearl, Morton, Philadelphia (Jefferson 1956)
Peddy, Robert Bycelle, Tampa (Tulane 1956)
Pedigo, Howard Keener, Fort Sam Houston, Tex. (U. Tenn. 1944)
Peterson, Arvid John Jr., Pierson (U. Miami 1956)
Pfaff, Robert John, Irving, Tex. (Long Island 1949)
Phillips, Philip Bernard, Pensacola (U. Ark. 1941)
Pollack, Herbert, New York (Cornell 1929)
Pollock, James Harold, Fort Myers (Duke 1956)
Pope, James Glynn, Harlan, Ky. (U. Louisville 1955)
Porter, James Jr., Orlando (Emory 1955)
Powell, Joseph Lee Jr., New Orleans (La. State U. 1948)
Pruitt, John Crayton, St. Petersburg (Emory 1956)
Purger, John Clayton, Miami (U. Miami 1956)

Quehl, Thomas Malcolm Leo, St. Petersburg (Tulane 1956)

Rader, Luke Ralph, Medford, Mass. (Virginia 1950)
Rawlings, Joseph Edwin Jr., St. Petersburg (Geo. Washington 1953)
Reeder, Robert Love, Knoxville, Tenn. (U. Tenn. 1956)
Register, Harold Eugene, Orlando (U. Miami 1956)
Reichling, Raymond John Jr., Miami (Wayne U. 1944)
Reilly, Leo Edward, New Orleans (Loyola 1951)
Reiner, Ernest August, Tampa (Columbia 1952)
Renuart, Adhemar William, Durham, N. C. (Duke 1955)
Reynolds, David Hyatt, Miami (Duke 1951)
Rice, Bernard Francis, St. Augustine (Temple 1956)
Robbins, Galen Patchell, Chestnut Hill, Mass. (Northwestern 1950)
Robinson, Henry Allen Jr., Decatur, Ga. (Emory 1956)
Rose, Howard Nathan, Miami Beach (Chicago 1956)
Rosenbach, Loren Marshall, West Palm Beach (U. Pitts. 1954)
Rosenberg, Donald George, Miami Beach (Emory 1956)
Ross, Elaine, Miami (U. Miami 1956)
Rountree, Mary Ellen, Miami (Bowman Gray 1956)
Rowell, Roger Ronald, Vidalia, Ga. (Georgia 1955)
Rudolph, Arthur Irving, Miami (U. Tenn. 1949)
Ruffolo, Eugene Henry, Jacksonville (Georgetown 1949)
Ruthig, Delmar William, Miami (Northwestern 1946)

Sabin, Frederick Chapman, Rochester, Minn. (Albany 1953)
Sandberg, James Rawlings, Coral Gables (Bowman Gray 1956)
Schandorf, Joseph Adjei, (Col.), Fort Lauderdale (Geneva 1951)
Schifman, Seymour, New York (Columbia 1951)
Schilling, Robert Charles, Daytona Beach (Temple 1949)
Schleifer, Carl Benjamin, Palmetto (Emory 1955)
Schwab, John Edward, Bluefield, W. Va. (Jefferson 1938)
Scokel, Paul William III, Jacksonville (Alabama 1954)
Scott, Walter Phelps, Emory Univ., Ga. (Tufts 1950)
Sewell, James Wesley, Miami (Tulane 1952)
Shector, Walter Eli, Tampa (Alberta 1949)
Sheppard, Mark, Fort Lauderdale (Washington 1955)
Shinner, John Joseph, Miami (U. Rochester 1954)
Siegel, Charles Isaac, Lancaster, Pa. (Hahnemann 1953)
Simmons, Frederic Rudolph, Albany, Ga. (U. Maryland 1950)
Simmons, Raymond Joseph, Rochester, N. Y. (U. Rochester 1943)
Sirot, Gustave, Bronx, N. Y. (St. U. New York 1951)
Slonim, Ralph Joseph Jr., Philadelphia (Hahnemann 1954)
Slosek, Edward Francis, Pensacola (Tufts 1937)
Smith, Ernest Caldwell Jr., Bartow (Emory 1955)
Smith, Jesse Graham Jr., Miami (Duke 1951)
Smith, Stanley Bertram, Miami Beach (Washington 1956)
Snider, Kenneth Bruce, Warrington (U. Maryland 1949)
Spoto, Nelson Joseph, Tampa (Tulane 1956)
Squires, John Brainard, Cincinnati (Ohio St. U. 1934)
Stansel, Horace Cary Jr., Tampa (Washington 1955)
Stanton, Eugene Stefan, Coral Gables (King Ferdinand I 1946)

(Continued on page 593)

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*Fishberg, A. M.: Hypertension and Nephritis, ed. 5, Philadelphia, Lea & Febiger, 1954, pp. 177-178.

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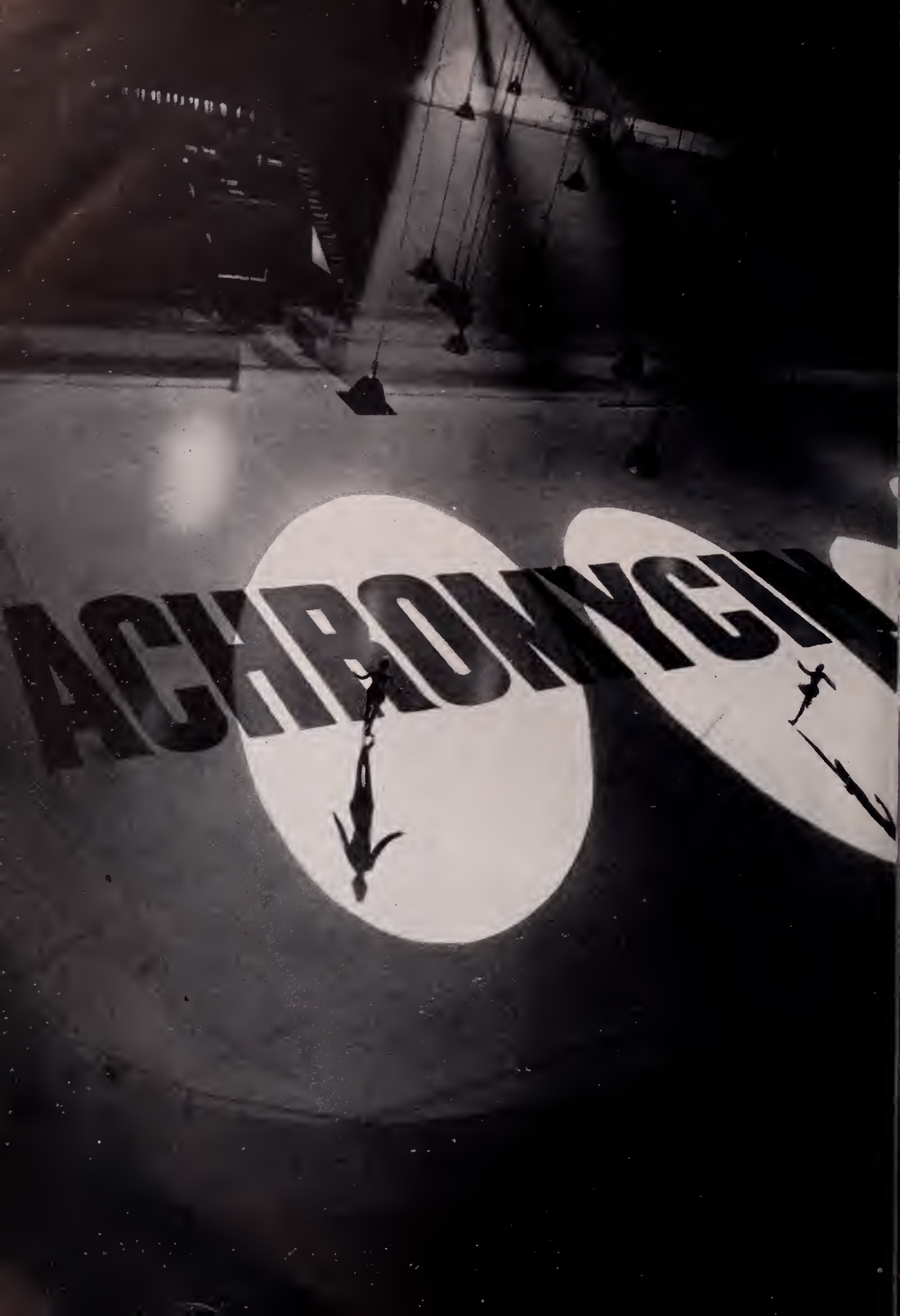
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English, *et al.*[4] noted that a daily dose of 1 to 1.5 Gm. of tetracycline resulted in urinary levels as high as 1 mg. per milliliter.

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References:
1. Finland, M., *et al.: J.A.M.A.* 154:561 (Feb. 13) 1954.
2. Prigot, A. and Marmell, M. *Antibiotics and Chemotherapy* 4:1117 (Oct.) 1954.
3. Trafton, H. and Lind, H.: *idem* 4:697 (June) 1954.
4. English, A., *et al.: idem* 4:441 (April) 1954.

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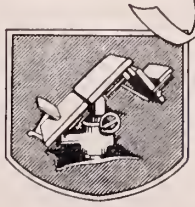

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(Continued from page 589)

Stein, Seymour, Elkins Park, Pa. (Hahnemann 1956)
Steinborg, Robert John, Fort Lauderdale (Emory 1948)
Stephenson, Barbara Angier, Atlanta, Ga. (Emory 1956)
Stevenson, Robert Louis, Daytona Beach (Indiana 1954)
Still, Robert Hillyer Jr., Jacksonville (Georgia 1953)
Stokes, James Arthur, Washington, D. C. (George Washington 1952)
Stone, John Samuel, (Col.), Tampa (Meharry 1956)
Stough, Warren Vesta, Miami (Chicago 1942)
Stratton, Hershel Ray, Atlanta, Ga. (Louisville 1946)
Surgnier, Richard Vernon, Gibsonton (U. Miami 1956)
Swanson, Eldon Carl, Pensacola (U. Nebraska 1933)
Tagliarini, Frank Philip, Tampa (Tulane 1955)
Taylor, Robert Franklin, Quincy (Emory 1956)
Thatcher, Arthur King, Fort Lauderdale (Ohio St. U. 1954)
Thatcher, Jackson Lee, New Orleans (La. St. U. 1951)
Thompson, Edgar Brown III, Coral Gables (Emory 1956)
Thornton, Frank James Jr., Tampa (Emory 1956)
Tippins, Henry Keener, Fort Walton Beach (Tulane 1945)
Traggis, Demetrius George, Miami (Johns Hopkins 1942)
Tsavaris, Louis John, Tarpon Springs (U. Miami 1956)
Tucker, Fred Cutting, Fort Wayne, Ind. (Indiana 1954)
Turkewitz, Hyman, Miami Beach (Chicago 1951)
Turner, John Calvin Jr., Miami (Johns Hopkins 1951)
Van De Water, Malcolm Stickle, Stuart (George Washington 1951)
Voight, Jack Albert, Tampa (Tulane 1956)
Walker, Thomas James, (Col.) Fort Lauderdale (Howard 1954)
Walton, Claiborne James, Munfordville, Ky. (Louisville 1953)
Waters, Jerome Francis, New York (N. Y. U. & Bellevue 1956)
Weems, Nathaniel Marion Jr., Miami (U. Miami 1956)
Werch, Solomon Carl, Miami (Illinois 1933)
Westphal, Benjamin Henry, Key West (Evangelists 1953)
Whiteside, James Arthur, Elmhurst, N. Y. (Alabama 1953)
Whitnack, John Doyle, Fort Bragg, N. C. (George Washington 1949)
Whittle, George Traver, Englewood, N. J. (U. Penn. 1950)
Wilbanks, George Dewey Jr., Tampa (Duke 1956)
Wildes, Jerome, West Palm Beach (Chicago 1953)
Wiley, Thomas Monroe Jr., Miami (Jefferson 1946)
Wilkerson, Ellis Walter III, Marianna (Tulane 1950)
Williams, Thomas Conrad Jr., Valdosta, Ga. (Georgia 1956)
Wilson, Frank Gavin, Miami (U. Miami 1956)
Wilson, John Marion Jr., Darien, Conn. (Cornell 1948)
Wilson, John Winkle Jr., Conway, S. C. (Duke 1949)
Windom, Robert Emerson, St. Petersburg (Duke 1956)
Wing, Kenneth Meldrum, Orlando (Emory 1956)
Winn, Margaret Elizabeth, Lake Butler (U. Miami 1956)
Winter, Abraham Tobias, Brooklyn (Tulane 1955)
Wold, Keith Clinton, Fort Lauderdale (Vermont 1951)
Womble, William Lansden, Winter Haven (George Washington 1955)
Woulfe, James Charles, N. Riverside, Ill. (Northwestern 1948)
Young, Cabell Jr., Winston-Salem, N. C. (Duke 1943)
Young, Roy Godfrey Jr., Birmingham, Ala. (Alabama 1951)
Zimmer, Alan Edward, West Palm Beach (Wayne U. 1956)

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- relieves pain promptly
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- tranquilizes without dulling
- well tolerated
- promotes healing
- maintains anacidity for hours
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**References and clinical trial supplies available on request.*

organomercurial diuretics "...permit ingestion of enough salt to make food palatable; without them, many patients would lose their appetites, a consequence of the salt-free diet which has occasionally been known to cause serious malnutrition."*

*Modell, W.: The Relief of Symptoms, Philadelphia, W. B. Saunders Company, 1955, pp. 265-266.

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OBITUARIES

John William McClane Sr.

Dr. John William McClane Sr., of Fernandina Beach, died in his sleep at his home on May 3, 1956, after suffering a coronary occlusion. He was 66 years of age. Interment took place in Royal Palm Cemetery in St. Petersburg.

Dr. McClane was born in Benkelman, Neb., on Sept. 2, 1889. Coming to Florida in 1905, he became a resident of St. Petersburg and attended the local schools. He received his medical training at Loyola University School of Medicine in Chicago, and upon graduation in 1914, he returned to Florida, where he was licensed to practice medicine in December of that year. He then entered private practice in St. Petersburg.

With the outbreak of World War I, Dr. McClane was the first physician to enlist in military service from the St. Petersburg area. He served as a captain in the 50th Infantry Medical Corps of the United States Army and, upon completion of his war service, joined the United States Veterans Administration as physician in charge of tuberculosis rehabilitation work at the Veterans Administration hospitals at Biltmore, Kennelworth and Oteen, N. C.

In 1924, Dr. McClane left the Veterans Administration service and returned to St. Petersburg, where he engaged in the private practice of medicine until 1932. At that time he was appointed to the United States Public Health Service and was stationed with the quarantine section in Presidio, Texas, later at Niagara Falls, N. Y., and from 1938 to 1945 at Miami. From Miami he came to Fernandina Beach 10 years ago to become Medical Director of the Nassau and Baker County Health Department for the Florida State Board of Health.

Dr. McClane was one of the pioneer members of the Pinellas County Medical Society. During the last 10 years of his life, while serving as health officer in Nassau and Baker counties, he was a member of the Nassau County Medical Society and since 1950 had been secretary and treasurer of that organization. He was a member of the Florida Medical Association and also of the American Medical Association.

Surviving are the widow, the former Zula Lee Langford, of Doniphan, Mo.; three daughters, Mrs. B. V. Farris, Ridgewood, N. J., Mrs. C. R. Boydston, Sacramento, Calif., and Mrs. E. L.

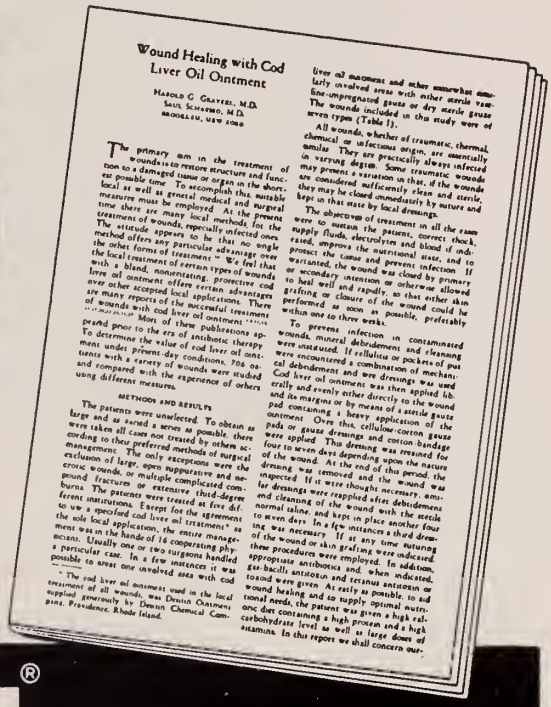
(Continued on page 626)

16 surgeons

participated in these

new extensive studies[1]

demonstrating that



Wound Healing with Cod Liver Oil Ointment

Harold G. Grayzel, M.D.
Saul Schapiro, M.D.
Brooklyn, New York

The primary aim in the treatment of wounds is to restore structure and function to a damaged tissue or organ in the shortest possible time. To accomplish this, suitable measures must be employed. At the present time there are many local methods for the treatment of wounds, especially infected ones. The attitude appears to be that no single method offers any particular advantage over the other forms of treatment.* We feel that the local treatment of certain types of wounds with a bland, nonirritating, protective cod liver oil ointment offers certain advantages over other accepted local applications. There are many reports of the successful treatment of wounds with cod liver oil ointment.[illegible] Most of these publications appeared prior to the era of antibiotic therapy. To determine the value of cod liver oil ointment under present-day conditions, 706 patients with a variety of wounds were studied and compared with the experience of others using different measures.

METHODS AND RESULTS

The patients were unselected. To obtain as large and as varied a series as possible, there were taken all cases not treated by others according to their preferred methods of surgical management. The only exceptions were the exclusion of large, open suppurative and necrotic wounds, or multiple complicated compound fractures or extensive third-degree burns. The patients were treated at five different institutions. Except for the agreement to use a specified cod liver oil treatment* as the sole local application, the entire management was in the hands of 16 cooperating physicians. Usually one or two surgeons handled a particular case. In a few instances it was possible to treat one involved area with cod liver oil ointment and other somewhat similarly involved areas with other sterile vaseline-impregnated gauze or dry sterile gauze. The wounds included in this study were of seven types (Table I).

All wounds, whether of traumatic, thermal, chemical or infectious origin, are essentially similar. They are practically always infected in varying degree. Some traumatic wounds may present a variation in that, if the wounds are considered sufficiently clean and sterile, they may be closed immediately by primary and kept in that state by local dressings.

The objectives of treatment in all the cases were to sustain the patient, correct shock, supply fluids, electrolytes and blood if indicated, improve the nutritional state, and to protect the tissue and prevent infection. If warranted, the wound was closed by primary or secondary intention or otherwise allowed to heal well and rapidly, so that either skin grafting or closure of the wound could be performed as soon as possible, preferably within one to three weeks.

To prevent infection in contaminated wounds, mineral debridement and cleansing were undertaken. If cellulitis or pockets of pus were encountered a combination of mechanical debridement and wet dressings was used. Cod liver oil ointment was then applied liberally and evenly either directly to the wound and its margins or by means of a sterile gauze pad containing a heavy application of the ointment. Over this, cellulose cotton gauze pads or gauze dressings and cotton-bandage were applied. This dressing was removed for four to seven days depending upon the nature of the wound. At the end of this period the dressing was removed and the wound was inspected. If it were thought necessary, similar dressings were reapplied after debridement and cleansing of the wound with the sterile normal saline, and kept in place another four to seven days. In a few instances a third dressing was necessary. If at any time nursing of the wound or skin grafting were indicated, these procedures were employed. In addition, appropriate antibiotics and, when indicated, gas-bacillus antitoxin and tetanus antitoxin or toxoid were given. As early as possible, to aid wound healing and to supply optimal nutritional needs, the patient was given a high caloric diet containing a high protein and a high carbohydrate level as well as large doses of vitamins. In this report we shall concern our-

* The cod liver oil ointment used in the local treatment of all wounds, was Desitin Ointment, supplied generously by Desitin Chemical Company, Providence, Rhode Island.

DESITIN® ointment

promotes "early, clean and healthy healing"

in
- **traumatic and infectious wounds**
- **burns (first, second, third degree)**
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- **pressure sores and ulcers**
- **pilonidal cysts and sinuses**
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1. Grayzel, H. G., and Schapiro, S.: Western J. Surgery, Obstet. & Gyn., Oct. 1956.

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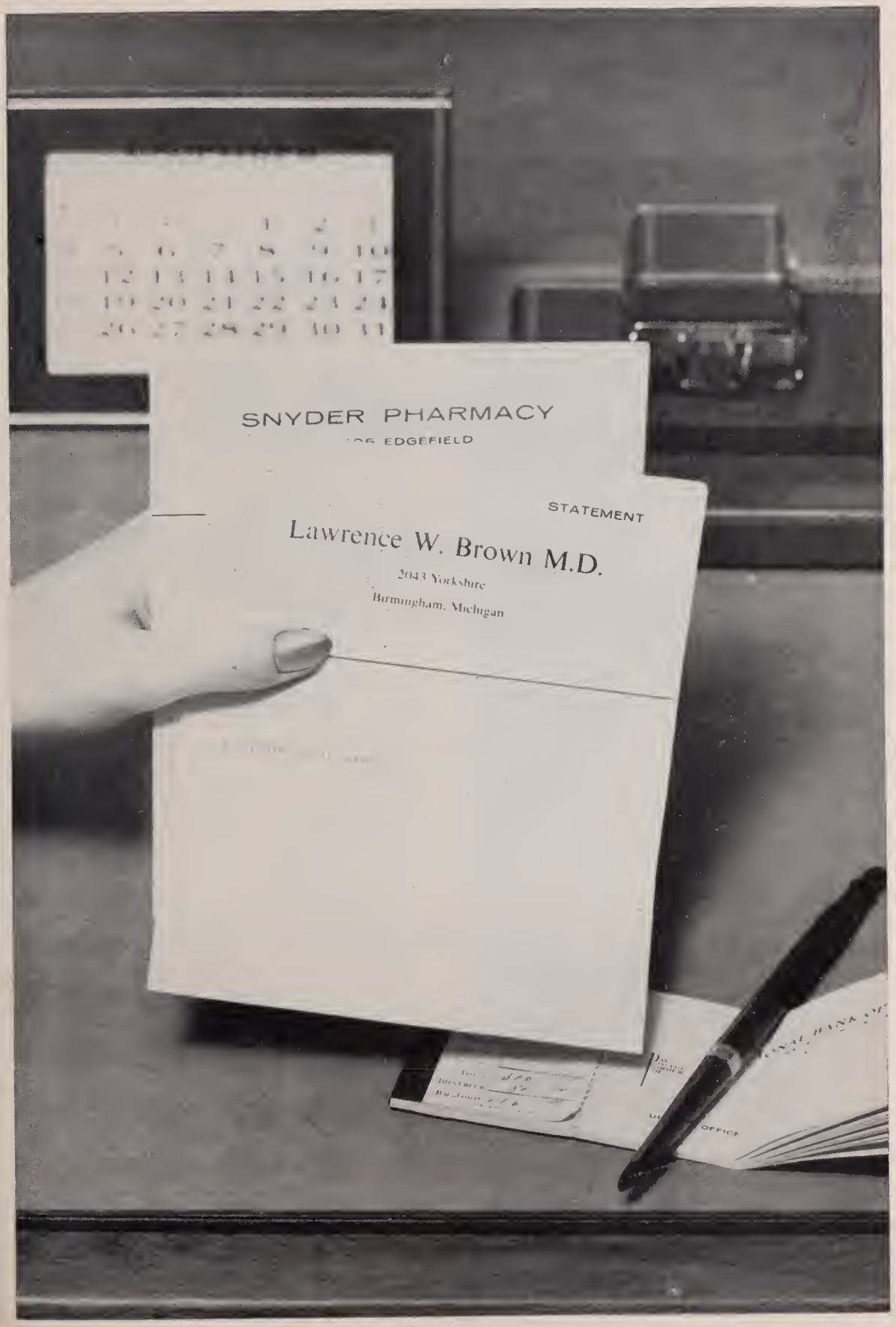
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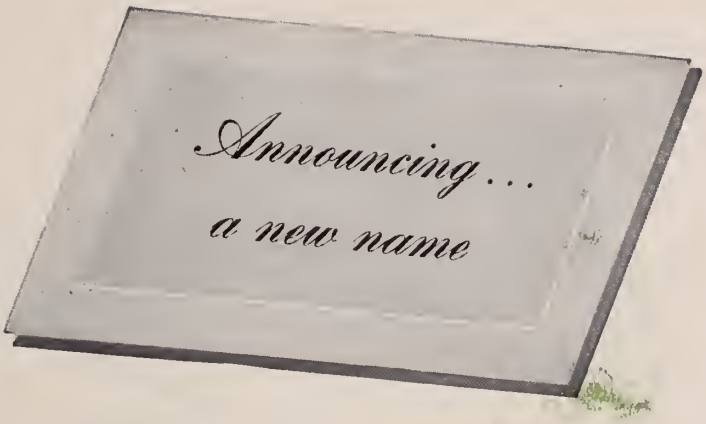
Auxiliary Program for Year on Way

A real spirit of understanding, determination and enthusiasm resulted from the Fall Conference and Board Meeting of the Woman's Auxiliary to the Florida Medical Association held at the Lago Mar Hotel in Fort Lauderdale, October 17-18. Armed with a renewal of friendship, many new friends were made and much information obtained. Those attending went away with renewed ambition and enthusiasm to carry out a program of projects well worthwhile and much needed in our state.

The Board of Directors meeting was called to order by the president, Mrs. Scottie J. Wilson. With the Chairman of the Advisory Council of the Florida Medical Association, Dr. John P. Ferrell, assisting and advising us, the following major business was voted:

1. To publish three issues of Medaux this year but to investigate the possibility of expanding to four issues next year through advertising from statewide concerns; the Medaux committee to bring a report and recommendation to the convention in May.



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relieves mental confusion and deterioration, mild memory defects and abnormal behavior patterns.

NICOZOL® *for senile psychoses*

REHABILITATION and RELEASE
from public and private psychiatric institutions for the mildly confused and mildly deteriorated aged patients may be accomplished by treatment with the NICOZOL formula. 1-2-3

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Pentylenetetrazol —— 100 mg.
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1. *Levy, S.* J.A.M.A. *153:1260, 1953.*
2. *Thompson, Lloyd & Proctor, Rich.* N. C. State, *Dec. 54*
3. *Thompson & Proctor,* Clinical Med *April, 1956*

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2. To incorporate during this year as a non-profit, educational and philanthropical corporation.

3. To continue obtaining a president's pin, the design of which will be the same for past presidents.

The committee to prepare the incorporation, working with the Advisory Council of the Florida Medical Association, Dr. John P. Ferrell, Chairman, is composed of Mrs. Richard F. Stover, chairman, Mrs. Herschel G. Cole, Mrs. Thomas C. Kenaston, Mrs. Wendell J. Newcomb, Mrs. William A. Hodges Jr. and Mrs. Robert F. Mikell.

The committee to design and obtain the president's pin consists of Mrs. Thomas C. Kenaston, chairman, Mrs. Lee Rogers Jr. and Mrs. Richard F. Stover as members.

The Conference was opened by the president, Mrs. Scottie J. Wilson and following announcements, the Auxiliary pledge was given. Mrs. Wilson introduced the president-elect, Mrs. Perry D. Melvin who presided.

We were fortunate to have three outstanding guest speakers at this Conference. Dr. James Reuling, chairman of the Legislative Committee and a member of the Board of Trustees of the A.M.A., participated in the legislative panel and was well received for his fine talk and his cooperation with the auxiliary. Mr. James Hughes, district manager of the Blue Cross-Blue Shield, participated in the public relations conference and panel and gave the auxiliary details of progress and problems of Blue Cross-Blue Shield. Dr. Arnold Eichert, superintendent of the South Florida Hospital for the Mentally Ill, gave us the highlights of the opening of that institution which will be about March 1, 1957. Our thanks are extended to these speakers who gave their time and effort to help us and to provide expanded ideas and information for our use in the years to come.

The AMEF goal, statewide, of the Auxiliary this year is $2500 and we hope to make this amount or more to aid our medical schools. Also, we will help educate the public to the need for voluntary contributions to the medical schools and will participate in National Medical Education Week next spring.

Safety programs will be sponsored during the year and stress will be laid upon making automobile riding safer. This is a new committee of the A.M.A. auxiliary and, although Florida does not have a chairman this year, this work will be carried forward under our program committee.

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Today's Health, in which the Florida Auxiliary has gone over 100 per cent of its quota for the past six years, will again be emphasized this year and we are hoping that every doctor in Florida will support this magazine by having it in his reception room. This is where many people get their only authentic health information other than what is told them by their private doctors.

Emphasis will be placed on regular legislation reports at monthly meetings of the local auxiliaries so that we shall be in a position to talk intelligently about medical legislation which will be coming before the new Congress and before our Florida Legislature.

The new history book was on display and emphasis was given to the keeping of correct records, not just by state, but by all components of the state auxiliary. Grandma's Kitchens (sufficient food in safe storage for any disaster) was stressed on Civil Defense as well as making up and keeping first aid kits, both at home and in the automobile.

Plans for the District Future Nurse Club meetings to be held this fall were given and stress was upon the need for recruitment in other allied fields of medicine as well as the field of nursing. Plans for the Future Nurses Clubs State Meeting to be held next March in Jacksonville were discussed and arrangements for care of the high school students attending this meeting were explained. Mrs. W. R. Gatling, Jacksonville, who is in charge of arrangement, has been the "early bird" and has plans made for the meeting at the Seminole Hotel.

Projects of the Southern Medical Auxiliary were discussed and special emphasis laid upon Doctors Day which is March 30 of each year. This is an event both the auxiliary members and doctors look forward to with a great deal of pleasure and it is also a day on which we honor our husbands. Florida's record in this project has been good and we are looking forward to better programs and projects this year.

The major complaints expressed of the meeting were that there is so much to learn in such a short time that perhaps this meeting should be two days rather than one afternoon and one morning only.

From the number attending (10 from Orlando, for instance, who drove to Cocoa, taking the train to Fort Lauderdale due to flooded roads after the storm) and from the enthusiasm and interest

(Continued on page 606)

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for the average patient in everyday practice

- well suited for prolonged therapy
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- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
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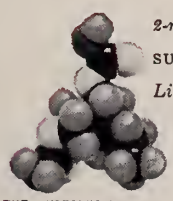

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ATARAXOID exerts the anti-rheumatic, anti-inflammatory activity of STERANE distinctly superior to previous steroids, effective in radically reduced dosage, and with minimal disturbance of electrolyte and fluid metabolism.

The ataractic effect is a central neuro-relaxing action – the result of a marked cerebral specificity – free of mental fogging and devoid of any major complications: no liver, blood or brain damage. This peace-of-mind component is also used in the lowest dosage range.

Supplied: Each green, scored, ATARAXOID oral tablet contains 5 mg. prednisolone (STERANE) and 10 mg. hydroxyzine hydrochloride (ATARAX). Bottles of 30 and 100.

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prednisolone and hydroxyzine

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combining the newest, safest tranquilizer, ATARAX® + the newest, most effective steroid, STERANE® (prednisolone)

simultaneously controls the symptoms and the apprehension

In Rheumatoid Arthritis, other collagen diseases, bronchial asthma and inflammatory dermatoses

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(Continued from page 602)

shown, it would seem feasible to extend the meeting another day.

The social hour and buffet supper following the board meeting on October 17 was an event that will long be remembered by those present. The conferences in conjunction with the Fall Board Meeting have been going on since 1950-51, the year Mrs. James Anderson was president. That year, we met in Tallahassee and had a speaker and trip to Chattahoochee afterwards. Since then the conference has expanded into a full fledged program of all our projects and we can easily say that every year it has become better and better—this last one being the best yet.

Mrs. Wilson, our president, has attended all the district workshop meetings held in conjunction with the District Meetings of the Florida Medical Association and this has helped to strengthen the understanding of auxiliary members throughout the state.

Though it doesn't seem possible, Christmas is almost upon us. From your Auxiliary, we extend to each doctor the best wishes and greetings for a Merry Christmas and Happy New Year, fruitful in advances to medicine and limitations on government medicine.

Mrs. Richard F. Stover.

BOOKS RECEIVED

Etiologic Factors in Renal Lithiasis. Compiled and edited by Arthur J. Butt, B.S., M.D., F.A.C.S. Pp. 401. Price, $12.50. Springfield, Ill., Charles C. Thomas, Publisher, 1956.

This book is written for a wide circle of investigators — urologists, surgeons, internists, endocrinologists, clinical chemists and other research workers interested in the problem of stone and related subjects. It deals with why calculi form in the urinary tract and how to treat patients in whose urinary tracts they do form, presenting frankly divergent views so that the present status of the subject is clear. Newer uses of the electron microscope, "Ultropak" microscope, and flame photometer for the study of urinary colloids and analysis of stone are described.

Dr. Arthur J. Butt of Pensacola, who compiled and edited this well illustrated volume, is among the 20 distinguished contributors. In the Foreword, Dr. William F. Braasch, Professor Emeritus of Urology, Mayo Foundation for Medical Education and Research, commented: "The editor of this book was first to observe that administration of hyaluronidase, and consequent release of hyaluronic acid, importantly influenced the character of urine of patients with calculi. He inferred that hyaluronidase increases the protective action of urinary colloids in preventing precipitation of crystalloids. Working in co-operation with other investigators, he has corroborated his hypothesis, both by laboratory and clinical observations. His investigations have brought about a change of thought in this field; the static concept has given way to a dynamic view which takes into consideration a chemical reaction in being rather than a mineralogic fait accompli.

"It is time that the various factors in the etiology of urinary calculi be reviewed and that the review be brought up to date. This survey of progress made is particularly welcome, not only because it is an intelligent

Outguessing your "Second Guessers" ...always a serious problem in OBESITY!

It's easy with DIOCURB!

This New Dosage form of dextro amphetamine sulfate is *not readily recognizable* by the most astute patient!

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SMALL, RED, SOFT GELATIN SPHERES, containing 5 mg. dextro amphetamine Sulfate.

Especially Effective... in Obesity!

Thin wall capsule releases amphetamine in as little as 90 seconds! Nonaqueous vehicle and micron particle size assures maximum therapeutic response.

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Dosage is definite and easy: two 2 mg. tablets at bedtime.

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LOS ANGELES

appraisal of advances made, but also because it can serve as a springboard for future workers in the field."

The ultimate objective of the book is a better understanding of the phenomena underlying pathologic states of the kidney and urine and their relationship to calculus disease.

Management of Strokes. By Keith W. Sheldon. Pp. 134. Price, $3.00. Philadelphia, J. B. Lippincott Company, 1956.

This work is based on observation of patients whose original medical diagnosis was "stroke." A few cases are included in the text to illustrate certain aspects of the problem. Attacking complacency and foggy thinking on this important subject, the author advocates a fresh thoughtful approach to the care of each case, and public education to that end. He notes that "so-called strokes" are the third ranking cause of death in the United States, with at least 500,000 people having some form of cerebral catastrophe each year, and pleads for a scientific diagnostic approach such as is utilized when a patient has a so-called "heart attack," "lung trouble," or "stomach condition." His book represents an endeavor to create interest in the adoption of an intelligent, aggressive approach to the problem and to stimulate interest in a neglected field. It is well illustrated and of convenient pocket size.

Ciba Foundation Colloquia on Ageing, Volume 2, Ageing in Transient Tissues. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Elaine C. P. Millar, A.H.W.C., A.R.I.C. Pp. 263. Illus. 96. Price, $6.75. Boston, Little, Brown and Company, 1956.

This volume records the second conference on aging sponsored by the Ciba Foundation. The papers and discussions deal with studies on the aging of tissues, the normal life of which is shorter than that of the organism as a whole. The book provides an excellent example of the conferences arranged by the Foundation to promote international cooperation in scientific research and will interest clinicians and research workers alike. A partial table of contents includes organ culture studies of fetal rat reproductive tracts, the age factor in some prenatal endocrine events, the regenerative capacity of ovarian tissue, the history and fate of redundant follicles, mitochondrial changes in different physiologic states, chronologic changes in placental function, modifications in the fetal development of the rat after administration of growth hormone, aging of the axillary apocrine sweat glands in the human female, and aging in human red cells. Twenty-seven authorities, from both sides of the Atlantic, participated in this symposium.

Epilepsy and the Law: *A Proposal for Legal Reform in the Light of Medical Progress.* By Roscoe L. Barrow and Howard D. Fabing, M.D. Pp. 177. Price, $5.50. New York, Paul B. Hoeber, Inc., 1956.

This book is the first major document to clarify the legal and social status of the epileptic in this country, and it provides a firm, factual basis on which to formulate corrective action for certain of the inequities that make the epileptic's position in society so insecure. A lawyer and a physician have collaborated in this analysis to show how the present laws concerning epilepsy came into force, what effects these laws have had on the epileptic, why the epileptic's right to marry has been restricted, why sterilization of epileptics was instituted, why a reappraisal of our laws governing issuance of drivers' licenses to epileptics is in order, how workmen's compensation laws work against epileptics, and a blueprint for action in bringing about change in the present laws restricting the activities of epileptics.

In the Foreword, Dr. Pearce Bailey, Director of the National Institute of Neurological Diseases and Blindness, observes that of approximately one and a half million epileptics in the United States, almost 80 per cent can have their seizures satisfactorily controlled by proper

(Continued on page 616)

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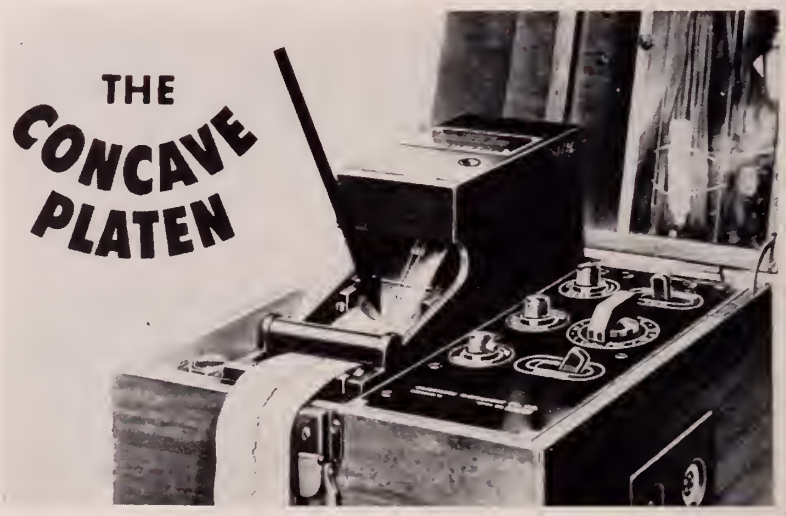

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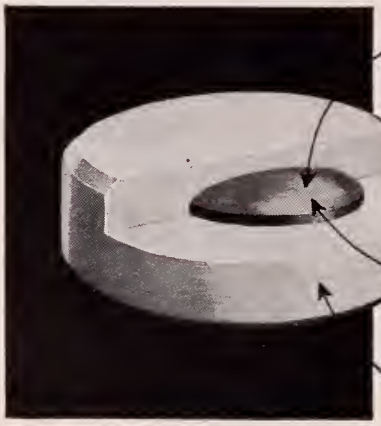

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Erythrocin in treating tonsillitis and otitis externa*

2/22/56 DISCHARGE SUMMARY

Patient, white male, age 4, entered the clinic on 2/13/56, with a history of yellow discharge from the right ear, a fever, and sore throat of two days duration.

Temperature orally was 100°, pharynx infected, tonsils inflamed, crusted purulent material seen in right ear canal; tympanic membrane normal. Diagnosis -- tonsillitis and otitis externa.

Culture revealed Staphylococcus aureus, coagulase positive, resistant to penicillin and sensitive to erythromycin.

ERYTHROCIN (erythromycin) was started in doses of 25 mgm/kg -- 400 mgm in 4 equally divided doses.

After 24 hours of therapy, patient was afebrile and comfortable. T = 99.6. Throat slightly infected. Secretions in ear canal were dry and both tympanic membranes were normal.

Culture on 2/15 showed no coagulase positive staphylococci or other pathogens. On 2/22, follow-up exam showed him to be completely asymptomatic and free of unusual physical findings. The drug was stopped at this time.

Final Diagnosis: tonsillitis and otitis externa due to Staphylococcus aureus.

Result: complete clinical bacteriologic cure after 9 days with ERYTHROCIN therapy.

*Communication to Abbott Laboratories

"clinical response good or excellent"

In one recent study, 18 patients with acute follicular tonsillitis and septic sore throat, were given erythromycin. Infecting organism was *Str. pyogenes*. The investigator stated, "*In all 18, the clinical response could be regarded as either good or excellent.*"[1]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when your prescription reads *Filmtab* ERYTHROCIN Stearate.

"toxicity lower in erythromycin-treated patients"

After a study of 208 patients treated with erythromycin (78), procaine penicillin (78) and a placebo (52), the investigator stated: ". . . *the incidence of toxicity* (compared to procaine penicillin) *was significantly lower in the erythromycin-treated patients.*"[1]

Actually, ERYTHROCIN stands on a remarkable record of safety. After four years, there's not a single report of a severe or fatal reaction attributable to erythromycin. Also, allergic reactions rarely occur. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), is available in bottles of 25 and 100, at all pharmacies.

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1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 29, New York, Medical Encyclopedia, Inc., 1955.
Idem p. 30.

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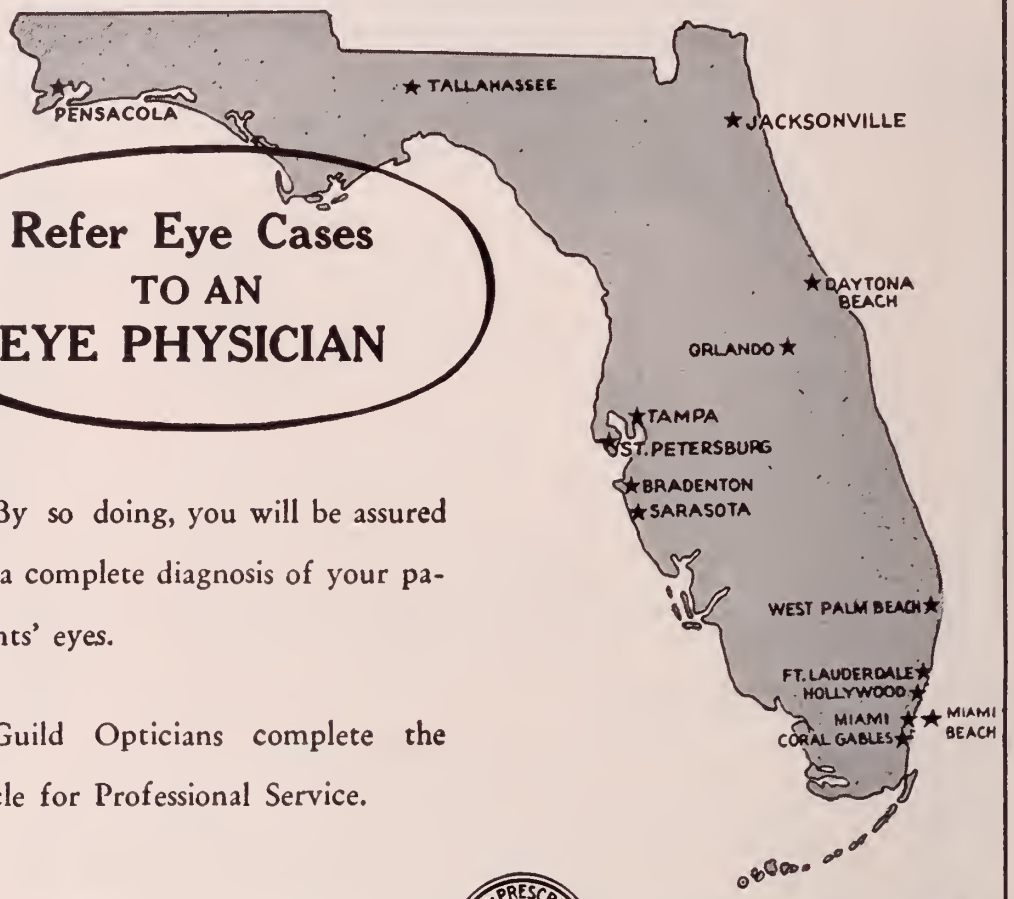

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(Continued from page 608)

medication, yet they stand isolated from the main stream of normal living, socially, economically, and psychologically. Of this book he writes: "It is a study, of course — a well-documented, objective appraisal of state laws governing the epileptic's ability to marry, to have children, to drive a motor vehicle, and to obtain employment. For all of its scholarship, however, this book is part of the literature of indignation. It documents a serious inequity and so can be a means of achieving the kind of public and professional understanding which must exist before there can be enlightened legal and social action."

The Menninger Story. By Walker Winslow. Pp. 350. Price, $5.00. Garden City, N. Y., Doubleday & Company, Inc., 1956.

Returning from a visit to the Mayo Clinic in 1908, Dr. Charles F. Menninger told his young sons that they were going to be doctors and help him establish a clinic like it in their home town of Topeka, Kan. Two of the three sons, Doctors Karl and Will, inspired by the powerful example set them by their father, did become physicians, and by 1920 the clinic they had visualized became a fact. From this beginning grew their famous center. One feature that set it apart from most others in America was that it came into being as an adjunct to the general practice of medicine. By 1953, the last year of Dr. Charles Menninger's life, the prophecy made in 1908 seemed to have been fulfilled. He and his sons had established one of the greatest psychiatric clinics in the world. To physicians in search of the best in psychiatric training, and for the mentally ill seeking the most modern treatment, Topeka had become a mecca.

As fascinating as the growth of their clinic is the personal history of the Menningers, and the story of their famous center is inseparable from their own outstanding lives. Wide experience in the mental health field led the author to perceive a new spirit here in American institutional psychiatry. This book is the result of his determination to discover what it was that made the Menningers and Topeka different.

Ciba Foundation Symposium on Histamine. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc. Pp. 472. Illus. 133. Price, $9.00. Boston, Little, Brown and Company, 1956.

The Ciba Foundation, jointly with The Physiological Society and The British Pharmacological Society, honors Sir Henry Dale in the presentation of this symposium on Histamine. Since research on histamine seems to be at a point at which important advances can be anticipated, this book has particular value in that it gathers together and correlates the latest findings of internationally known authorities. It offers an important single source of material on the rapid advances being made in this field of research today. Eighteen distinguished contributors cover such subjects as the occurrence of histamine in the body, the release of histamine, the origin and significance of histamine in the body, the origin and fate of histamine in the body, the location of histamine in the body, and the mechanism of histamine research. The papers and discussions will prove informative and stimulating to workers in this field throughout the world.

Of Water, Salt and Life: *An Atlas of Fluid and Electrolyte Balance in Health and Disease.* Pp. 72. Plates 31. Price, $7.50. Milwaukee, Wis., Lakeside Laboratories, Inc., 1956.

This reference book incorporates the abundant new knowledge concerning an increasingly significant area of clinical medicine. Two developments in research technics, the flame photometer and the use of radioactive isotopes as tracers, have made possible more accurate measurements and precise evaluation in diagnosis and therapy. Many of the investigators whose work has contributed to current knowledge are cited in the bibliography.

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The complex physiologic ramifications of fluid and electrolyte metabolism are elucidated by three graphic devices employed in the 31 six color illustrations of the atlas. The first of these is a new and unique diagrammatic representation of the body's three fluid compartments. Another is an adaptation of the Gamble method of depicting acid base balance by distinctively colored twin columns divided into segments representing the separate electrolytes. The third one is the representation of the primary organ of fluid and electrolyte output, the nephron. This appears in all plates illustrating clinical situations in which renal action is important.

The atlas is divided into four sections: basic physiologic considerations; the pharmacology of diuresis and antidiuresis; disorders of fluid and electrolyte balance; and fluid and electrolyte replacement therapy.

Ciba Foundation Colloquia on Endocrinology, Volume IX, Internal Secretions of the Pancreas. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E., M.A., M.B., B.Ch., and Cecilia M. O'Connor, B.Sc. Pp. 292. Illus. 100. Price, $7.00. Boston, Little, Brown and Company, 1956.

Between January 1950 and July 1955 the Ciba Foundation organized and held on its premises in London 36 small international conferences, in the early days mostly on subjects within the field of endocrinology. Although the range of conferences has broadened, the Foundation finds at least one opportunity each year to maintain its interest in endocrinologic research. A colloquium on hormonal factors in carbohydrate metabolism was held in 1952, and a follow-up colloquium on the nature and actions of the internal secretions of the pancreas is here presented. It covers such subjects as the metabolic effects of alpha cell destruction, the pituitary growth hormone and blood insulin activity, the control of the secretory activity of the islets of Langerhans, fractionation of insulin, the chemical structure of insulin, a concept of the three-dimensional structure of insulin, insulin and glucagon, the action of glucagon on liver phosphorylase, the hepatic action of insulin, some problems of permeability of tissue cells to sugars, and pancreatic islet and growth. Distinguished physicists, chemists and biologists from various countries are the contributors to this well illustrated, stimulating volume.

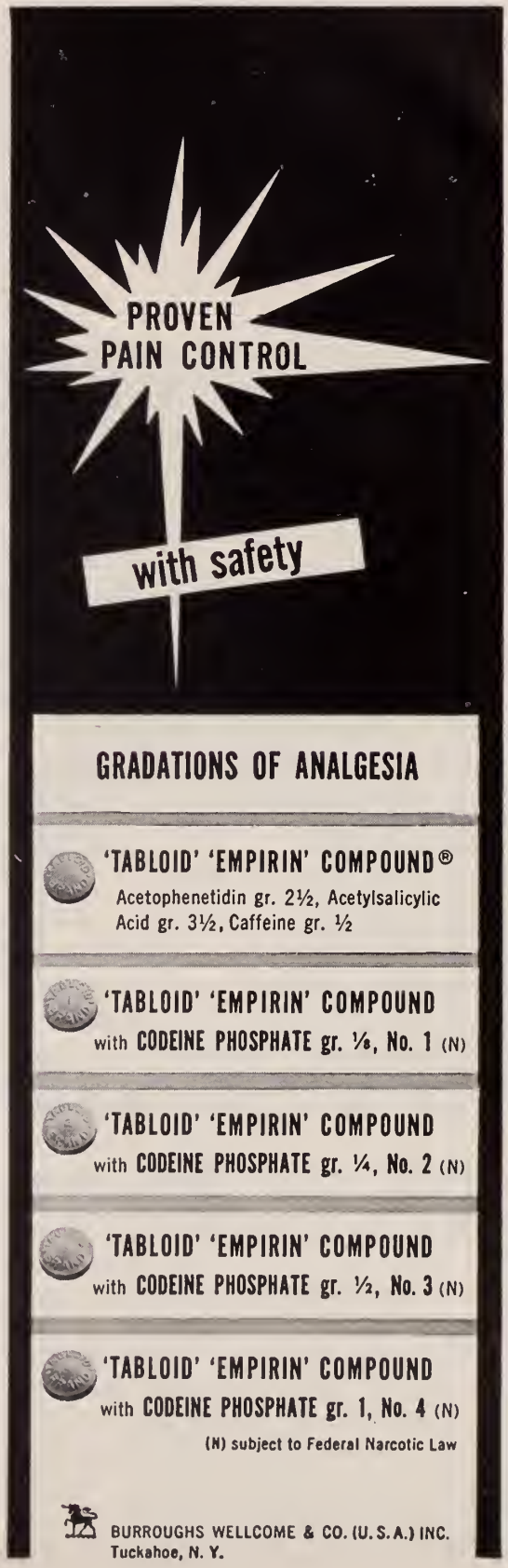
New and Nonofficial Remedies 1956. Council on Pharmacy and Chemistry of the American Medical Asssociation. Pp. 540. Price, $3.35. Philadelphia, J. B. Lippincott Company, 1956.

This annual publication of the Council on Pharmacy and Chemistry of the American Medical Association contains descriptions of drugs evaluated on the basis of available scientific data and reports of investigations. It deals with agents proposed for medicinal or adjunctive use in or on the human body for the diagnosis, prevention or treatment of disease. The 1956 edition reflects important changes in content that have been made to implement the new program of operation for evaluation of drugs instituted during 1955. The scope of the book no longer is restricted only to descriptions of drugs having established uses, but has been expanded to provide for the inclusion of information on all available new drugs. Dosage forms and sizes, the names of manufacturers, and monographs describing ready-prepared mixtures of two or more drugs have been eliminated to permit more emphasis on basic information. When considered necessary, simultaneous or combined use of two or more drugs is discussed in monographs on the individual drugs or in general statements on classes of drugs to which they belong.

Medical Writing. MD International Symposia, No. 2. Pp. 66. Price, $3.00. New York, M D Publications, Inc., 1956.

The panel of authors participating in this symposium includes such distinguished editors of leading medical journals, medical historians, clinicians and investigators as Drs. Henry E. Sigerist, Hans Selye, Hugh Clegg, Walter

(Continued on page 626)



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Consommé can be served hot with crisp croutons, or cold and jellied in shimmering peaks. Puréed vegetables folded into a well-beaten egg can be baked to a puff, or molded in gelatin. Finely chopped beef moistened with broth spreads for a sandwich—mixed with bread crumbs, it shapes into patties. Eggs can be soft or hard cooked by simmering—or scrambled in a double boiler.

Serve prettily for eye appeal—

Chopped meat can be shaped like a chop—minced chicken like a drumstick—before baking. And flaked fish in lemon gelatin looks true to nature when your patient uses a mold.

White potatoes mashed with a little broth whip up creamy and light with cottage cheese. And mashed sweet potatoes made smooth with orange juice can be baked in the orange shells.

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Rice cooked in pineapple juice, water, and sugar makes a golden dessert. And for a gay parfait—alternate layers of farina pudding with puréed plums. Then put a sparkling cube of clear jelly on top.

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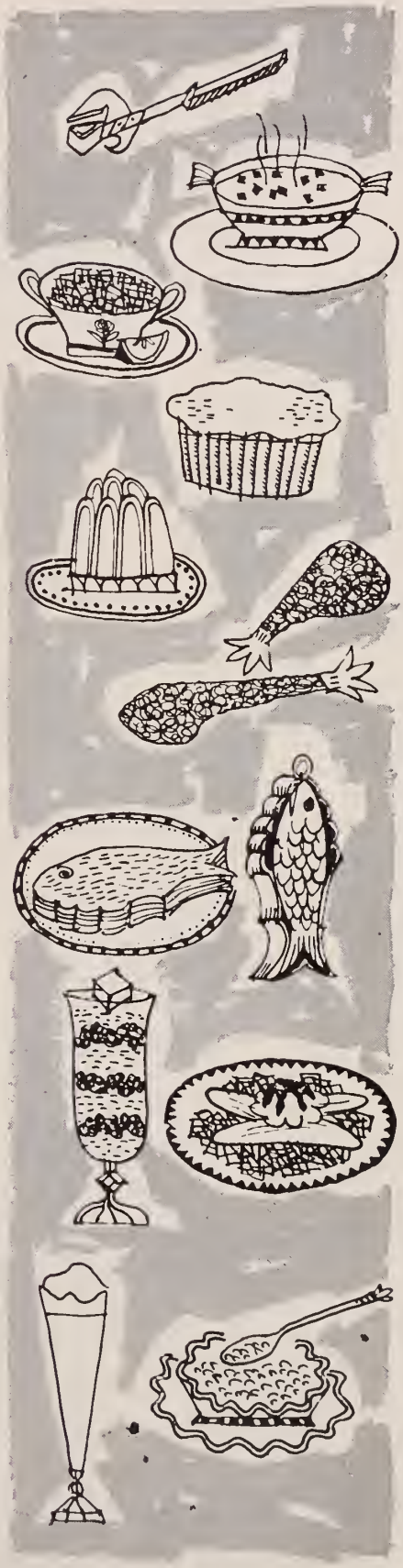

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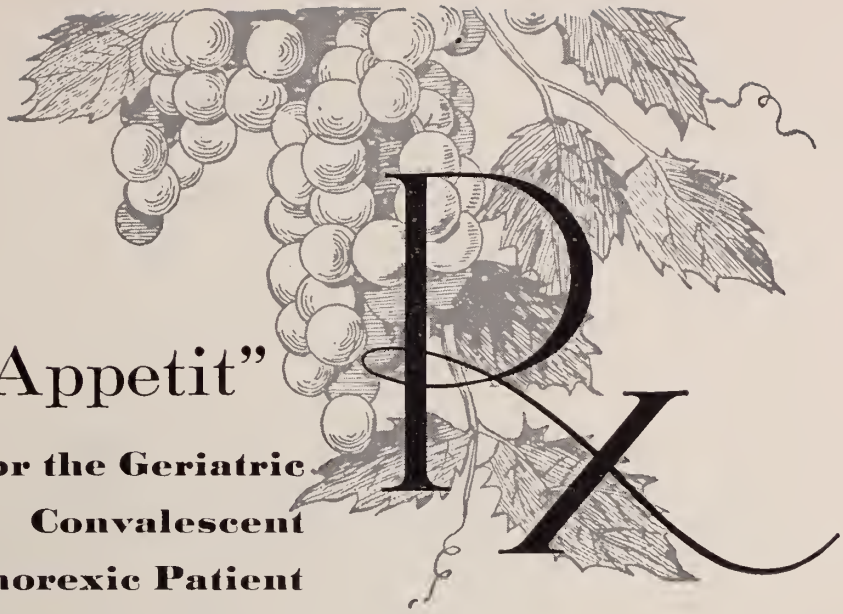

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And wine can help brighten the often unappealing character of special or restricted dietaries—a psychological boost of inestimable value to the debilitated and depressed patient.

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(Continued from page 617)

C. Alvarez and Félix Marti-Ibañez, all united in the field of medical writing by a common denominator—their creativity. The physician will find here not only good and practical advice on how to write but also on how to think, and even on the art of reappraising words to determine which, like old coins, are worn by use and which still glitter w th all their original luster. The physician is also advised how to marshal his ideas before setting pen to paper, and how to improve his style and the content of his writing by studying the literary and scientific masterpieces of all time. The sound advice and practical examples presented here should prove of inestimable value to both the novice and the experienced medical writer who accepts the fact that the more one knows about anything, the more one should try to learn about it.

Hypnotic Suggestion: *Its Role in Psychoneurotic and Psychosomatic Disorders.* By S. J. Van Pelt, M.B., B.S. Pp. 95. Price, $2.75. New York, Philosophical Library, 1956.

This book tells the general practitioner and those intending to specialize in the treatment of psychoneurotic and psychosomatic disorders what they need to know about the author's modern method of treating these disorders by hypnotherapy. Twelve detailed case histories illustrate the essential points of diagnosis and treatment.

(Continued from page 594)

Fornel, Hillcrest, Md.; two sons, Dr. John W. McClane Jr., Fernandina Beach, and James K. L. McClane, a student at Union Seminary, Richmond, Va.; two sisters, Mrs. R. B. DuBoise and Mrs. Paul A. Davis, both of St. Petersburg; and nine grandchildren.

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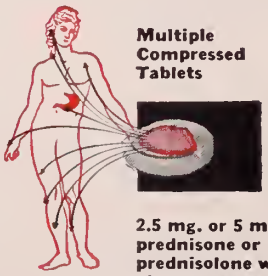

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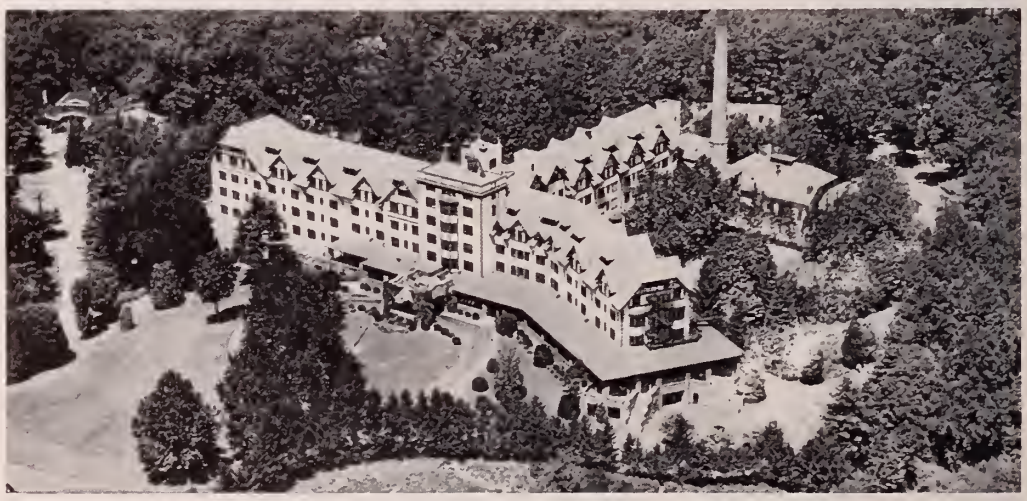

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SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Total Members
Alachua	Albert G. Love IV, Gainesville	G. Leonard Emmel, Gainesville	2nd Tues.	59
***Bradford, Gilchrist, Union**				
Bay	Joseph H. Morris, Panama City	John J. Hollomon Jr., Panama City	1st Tues.	30
Brevard	Isabel Roberts, Melbourne	Jack T. Bechtel, Eau Gallie	2nd Tues.	41
Broward	Thomas F. Huey Jr., Fort Lauderdale	Anthony C. Galluccio, Hollywood	4th Tues.	144
Columbia	Thomas H. Bates, Lake City	Clifton G. York, Lake City	1st Mon.	10
***Baker**				
Dade	Hunter B. Rogers, Miami	Vincent P. Corso, Miami	1st Tues.	780
DeSoto-Hardee-Highlands-Glades	Merle C. Kayton, Wauchula	Roland W. Banks, Wauchula	1st Tues.	27
Duval	Joseph J. Lowenthal, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	323
***Clay**				
Escambia	Gretchen V. Squires, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	108
***Santa Rosa**				
Franklin-Gulf	Harold B. Canning, Wewahitchka	Photis J. Nichols, Apalachicola	Last Wed.	6
Hillsborough	James N. Patterson, Tampa	James A. Winslow Jr., Tampa	1st Tues.	203
Indian River	Vernon L. Fromang, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	10
Jackson-Calhoun	Richard H. Schulz, Marianna	Francis M. Watson, Marianna	Quarterly	17
Lake	Geoffrey H. Binneveld, Leesburg	J. Basil Hall, Tavares	1st Wed.	33
***Sumter**				
Lee-Charlotte-Collier-Hendry	Joseph L. Selden Jr., Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	46
Leon-Gadsden-Liberty-Wakulla-Jefferson	Robert H. Mickler, Tallahassee	Odis G. Kendrick Jr., Tallahassee	Quarterly	71
Madison	Candler K. Hayes, Madison	Wilmer J. Coggins, Madison		8
Manatee	Richard V. Meaney, Bradenton	Eugene E. Biel, Bradenton	2nd Tues.	29
Marion	William J. McGovern, Ocala	Robert L. Gibson, Ocala	3rd Tues.	33
***Levy**				
Monroe	Allen Shepard, Key West	William R. Ploss, Key West	1st Thurs.	14
Nassau	Benjamin F. Dickens, Fernandina Bch.	David D. Bennett, Callahan	1st Thurs.	9
Orange	Thomas C. Butt, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	205
***Osceola**				
Palm Beach	Walter R. Newbern, West Palm Beach	Horace D. Atkinson, West Palm Beach	4th Mon.	150
Pasco-Hernando-Citrus	Gail M. Osterhout, Inverness	W. Wardlaw Jones, Dade City	2nd Thurs.	17
Pinellas	Percy H. Guinand, Clearwater	Whitman C. McConnell, St. Petersburg	1st Mon.	249
Polk	James T. Shelden, Lakeland	Marion W. Hester, Lakeland	2nd Wed.	111
Putnam	Bennie J. Massey, Palatka	Bernard E. Kane, Crescent City	2nd Tues.	10
St. Johns	Reuben J. Plant Jr., St. Augustine	Roy E. Campbell, St. Augustine	3rd Tues.	21
St. Lucie-Okeechobee-Martin	Alfred J. Cornille, Fort Pierce	Adrian M. Sample, Fort Pierce	3rd Thurs.	26
Sarasota	Eugene D. Liddy Jr., Sarasota	Karl R. Rolls, Sarasota	2nd Tues.	64
Seminole	William V. Roberts, Sanford	Terry Bird, Sanford	2nd Tues.	20
Suwannee	Shirley L. Hadden, Live Oak	Hiram B. Curry, Jasper	1st. Sat.	12
***Hamilton, Lafayette**				
Taylor	Ralph J. Greene, Perry	John H. Parker Jr., Perry	Last Fri.	5
***Dixie**				
Volusia	Theodore F. Hahn Jr., DeLand	Achille A. Monaco, Daytona Beach	2nd Tues.	89
***Flagler**				
Walton-Okaloosa	Henry C. White Jr.. Fort Walton Bch.	George W. Barrow Jr., Crestview	3rd Tues.	22
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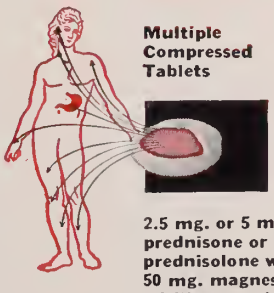

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References: 1. Boland, E. W., *J.A.M.A.* **160**:613, (February 25,) 1956. 2. Margolis, H. M. *et al*, *J.A.M.A.* **158**:454, (June 11,) 1955. 3. Bollet, A. J. *et al*, *J.A.M.A.* **158**:459, (June 11,) 1955.

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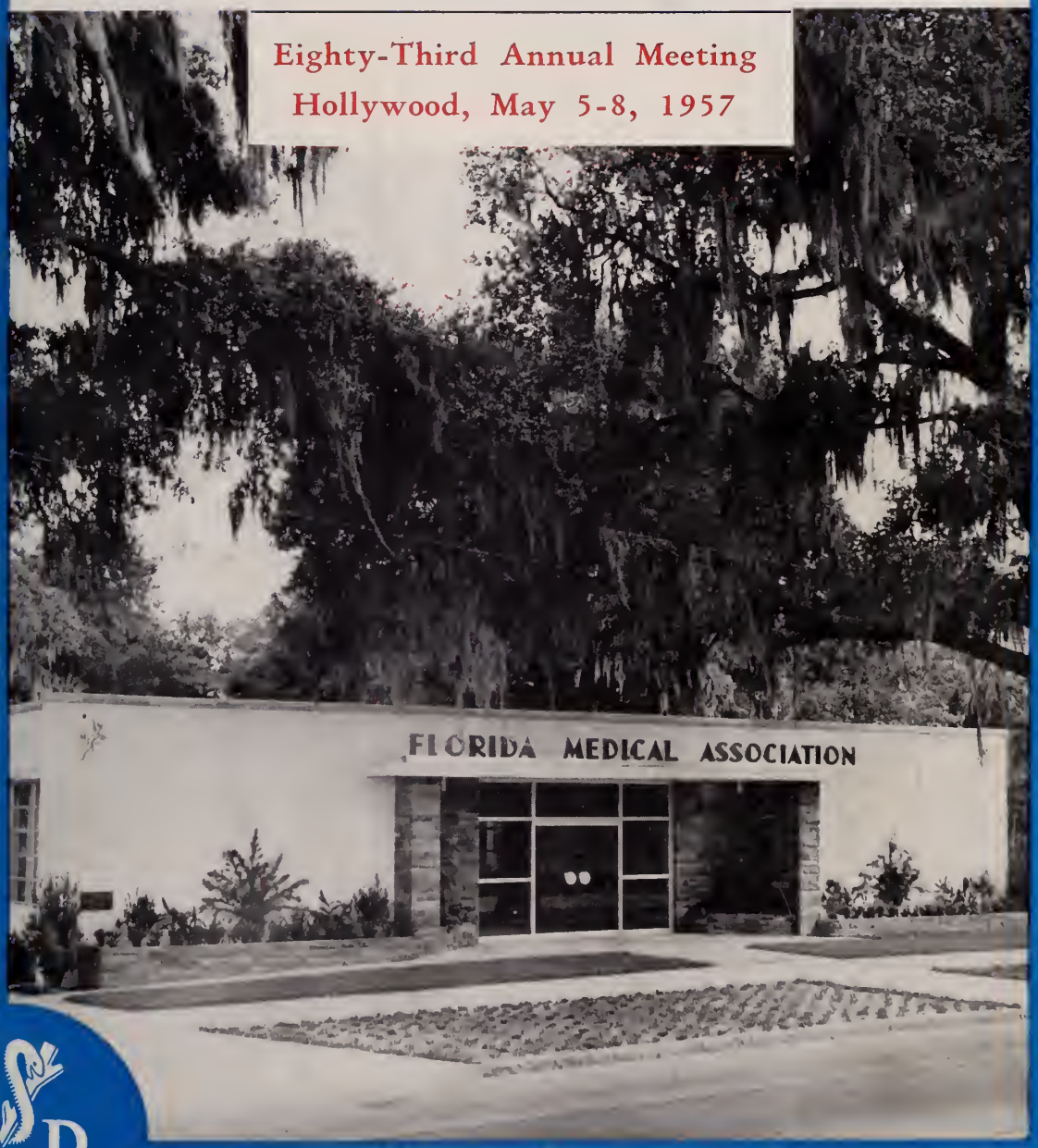

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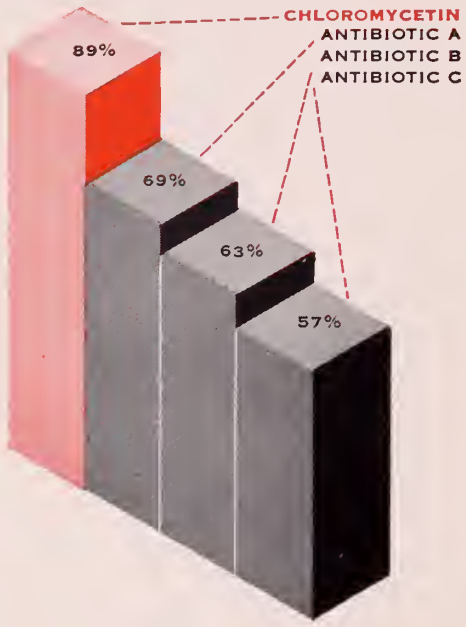

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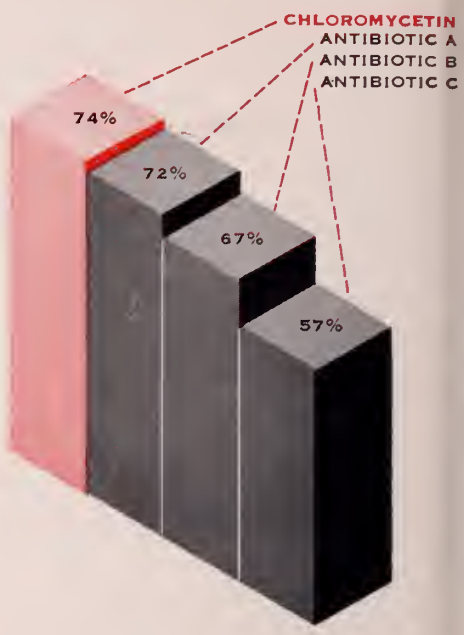

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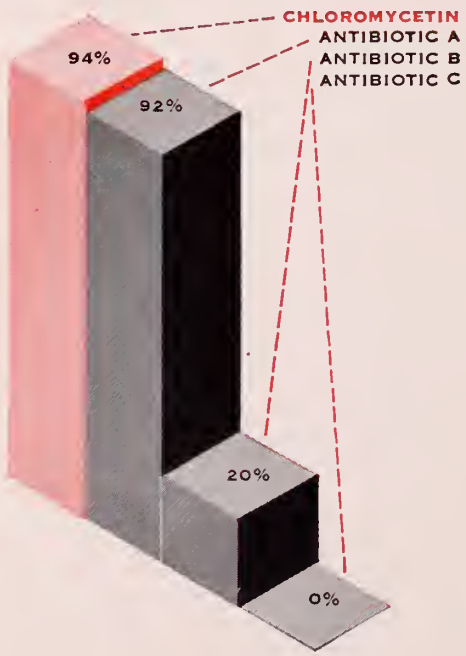

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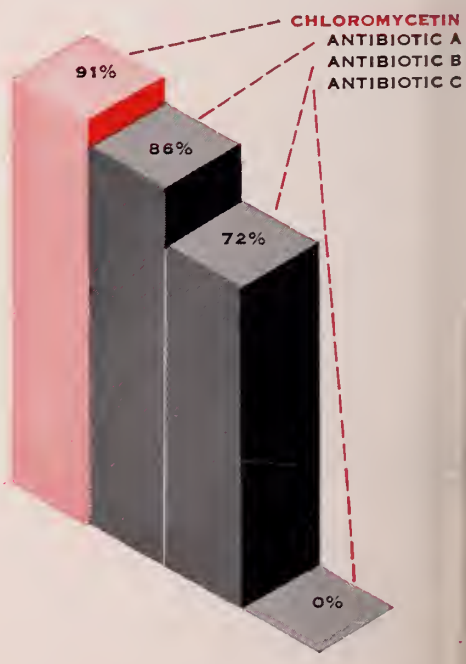

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References (1) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305 (Jan. 22) 1955. (2) Austrian, R.: *New York J. Med.* 55:2475 (Sept. 1) 1955. (3) Murphy, F. D., & Waisbren, B. A., *in* Murphy, F. D.: Medical Emergencies: Diagnosis and Treatment, ed. 5, Philadelphia, F. A. Davis Company, 1955, p. 557. (4) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (5) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (6) Kass, E. H.: *Am. J. Med.* 18:764, 1955. (7) Tebrock, H. E., & Young, W. N.: *New York J. Med.* 55:1159 (Apr. 15) 1955.

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ltemeier, Cul-
, Sherman, Cole,
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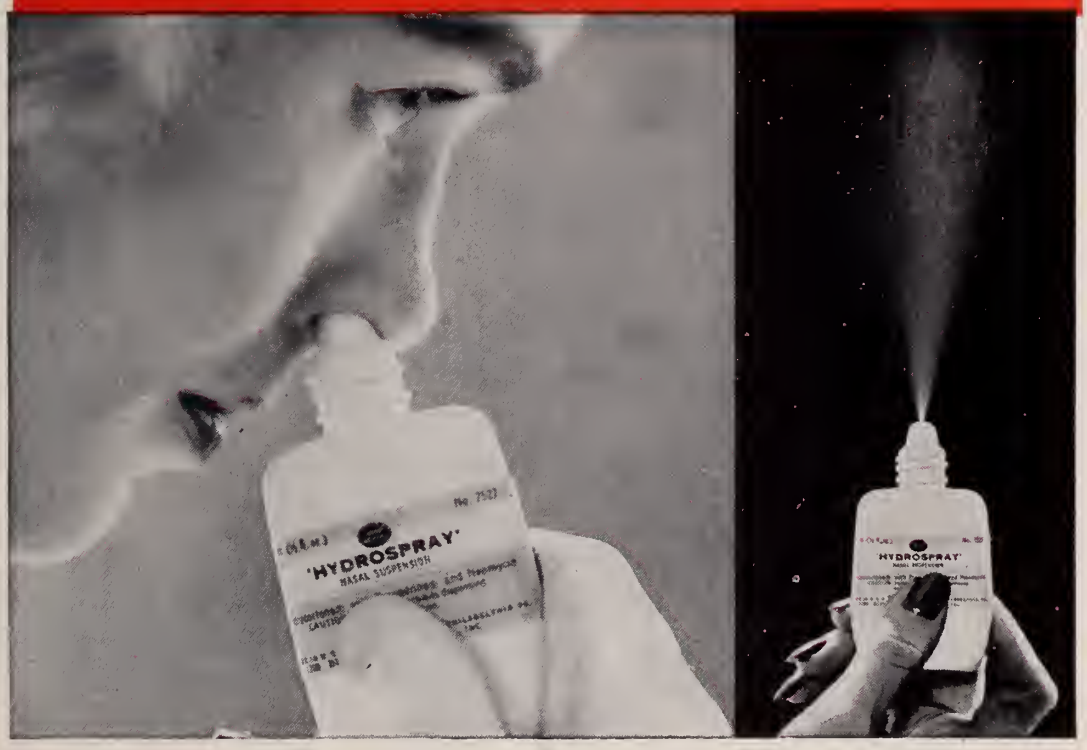

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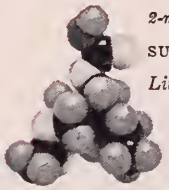

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†Abrahamson, I. A., Jr., and Abrahamson, I. A., Sr.: Am. J. Ophth. *42*:482, 1956.

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Vagal Arrhythmias in Succinylcholine-Modified Electroshock Therapy

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During succinylcholine-modified electroshock therapy in September 1953 one of us (F. E. B.) noted profound bradycardia in a patient. As a result of this experience, over 100 electroshock treatments in 35 patients comprised the material for our initial study of the subject in the subsequent few months. This report is concerned with the changes in cardiac rate and rhythm observed during the first 100 treatments.

In our procedure the patient was placed on the treatment table, and a baseline electrocardiogram was taken on a single channel direct-writing machine. A baseline blood pressure was usually obtained at this point. Succinylcholine in a dose ranging between 20 and 60 mg. was then injected intravenously as rapidly as possible with continuous electrocardiographic monitoring. The blood pressure was usually taken again just prior to the electroshock, which was administered within 30 to 60 seconds after completion of the injection. The electrocardiograph was turned off during the time of electric stimulus and for the short period of subsequent major convulsive movements. The resumption of electrocardiographic monitoring always occurred during the period of postconvulsive tachycardia. The blood pressure was usually recorded during this period of tachycardia. The electrocardiograph continued to run until muscle function and full respiration returned and the baseline rhythm was again recorded.

The subjects consisted of 25 men and 10 women ranging in age from 21 to 57, with the majority between 20 and 30. Fifteen out of the 35 had only one treatment monitored by the electrocardiograph. The remainder had from two to nine treatments fully recorded. Eight patients had five or more electrocardiographically monitored studies. Pentothal Sodium was given prior to electroshock in a few instances. Those patients who, on repeated study, consistently exhibited changes of a vagal character in cardiac rate and rhythm were given atropine in varying doses from 15 to 60 minutes prior to some of the treatments.

In general, the following sequence of events tended to occur. Within seven to 15 seconds after the injection of the succinylcholine, muscle fasciculation usually started with a facial grimace; the generalized fibrillary twitching lasted approximately 15 to 20 seconds, and during this time the blood pressure tended to rise. Frequently, the cardiac rate speeded slightly during the muscle fasciculation and also frequently slowed just prior to the institution of electroshock, which was given when total paralysis including respiratory arrest occurred, approximately 30 to 60 seconds after the injection. Immediately following the convulsive movements produced by electroshock, a pronounced sinus tachycardia invariably occurred. The postconvulsive tachycardia lasted from one to four minutes and was associated with an elevated blood pressure. Prior to the return of respiratory function, a bradycardia or shift in pacemaker often occurred. As a rule, the respiratory paralysis did not last longer than two to six minutes, and all muscle function ordinarily returned in the same period.

Twenty-seven out of the 35 patients had significant bradycardia (below 60) or displacement of the pacemaker consistent with a vagal effect in the postconvulsive period during one or more of the treatments (table 1). Atropine in proper dosage appeared to be completely effective in eliminating bradycardia or changes in the pacemaker. Use of oxygen with artificial respiration (manually compressed bag) not only seemed to minimize ventricular ectopic beats and runs of ventricular tachycardia, but also had some influ-

Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami Beach, May 14, 1956.

Table 1. — Certain Electrocardiographic Changes Noted in Thirty-Five Patients

Electrocardiographic Finding	Number of Patients*
1. Significant cardiac effect of succinylcholine	17†
2. Postconvulsive tachycardia (130 or more per minute)	35
3. Postconvulsive bradycardia (60 per minute or below)	20
4. Postconvulsive change in P-R interval of more than .04 second.	12
5. Postconvulsive premature atrial discharges	14
6. Postconvulsive "coronary sinus" discharges	10
7. Postconvulsive nodal discharges	14‡
8. Postconvulsive premature ventricular discharges (two or more in succession)	5
9. Postconvulsive second degree block	2
10. Postconvulsive upright P wave, normal QRS, and P-R interval less than .10 second	4

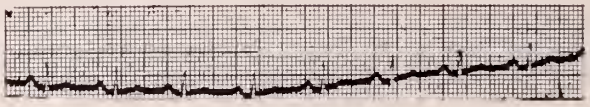
* This figure indicates the number of patients exhibiting the finding in one or more treatments.
† A decrease in base rate of 20 per minute, or below 60 per minute, or a shift of the pacemaker. The figure is conservative as electroshock always interrupted this period of observation.
‡ May include runs of nodal tachycardia.

ence in lessening the degree of bradycardia or pacemaker shifts, even when atropine was not given.

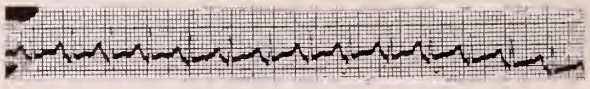
Discussion

Succinylcholine (or diacetylcholine) was first synthesized by Hart and Taveau in 1911 and later by Glick in 1941.[1] Its pharmacology was initially formulated by Castillo and DeBeer in 1950 and reviewed by Bourne, Collier and Somers[1] in 1952. It resembles decamethonium and appears first to stimulate and then depress mammalian striated muscle. This action is in contrast to the wholly depressing effect of d-tubocurarine. It differs from decamethonium by being hydrolized by pseudocholinesterase and to a far less degree by true cholinesterase. Since succinylcholine is destroyed by cholinesterases, neostigmine and other drugs that inhibit cholinesterase prolong the action of succinylcholine. This effect is in contrast to that of d-tubocurarine, which is inhibited by neostigmine. Side effects of succinylcholine include a nicotinic effect which raises the blood pressure with large doses (25 times the relaxant dose).[1] It is not hypotensive in dogs and cats. The drug may cause some salivation and is a weak histamine liberator.

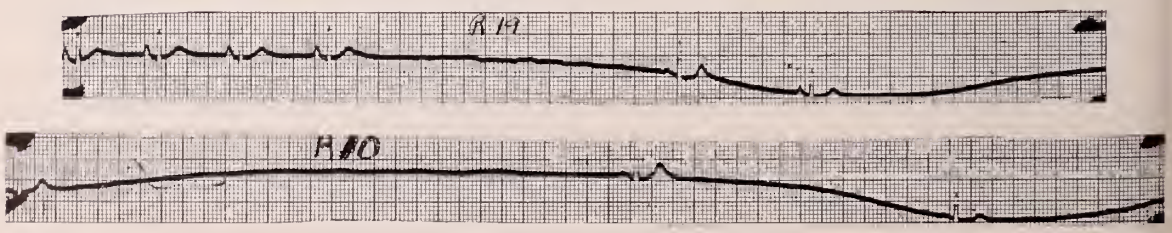
Clinically, one can give 5 to 300 mg. in a single dose intravenously, and as much as 2,300 mg. by intravenous drip over three hours with no undue harm. On an ordinary dose of 20 to 60 mg., initial muscle bundle contractions start in 12 to 15 seconds after the injection is given. The patient usually feels uncomfortable, and for this reason Pentothal Sodium is often used. The muscle fasciculation lasts for 15 to 20 seconds; then paralysis occurs for two to six minutes, followed by return of muscle function in another three or four minutes. Smaller doses give less, and larger doses give more and longer paralysis. In effective doses, all cause respiratory arrest. Out of 546 patients in the series of Bourne and his associates,[1] only five had apnea longer than eight minutes and none longer than 15 minutes. They did not note any rise in blood pressure on single doses (which is not in agreement with our usual findings), but did note a steady rise on intravenous drip. As the drug is hydrolized by pseudocholinesterase, patients with malnutrition,



Normal — Rate 100

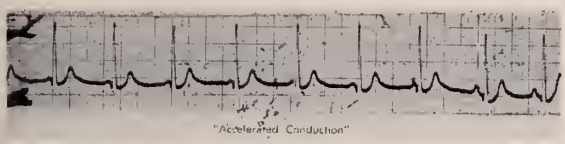


Sinus Tachycardia following the convulsive movements of electroshock therapy — Rate 150



Reflex vagal sinus bradycardia immediately following strip II

Figure 1.



Upright P, normal QRS, P-R interval 0.06 to 0.08 sec. The last two beats are sinus with a P-R interval 0.12 sec.

Figure 2.

disease of the liver, and certain other conditions should not be given the drug.[1]

We postulate a reflex vagal origin for the bradycardias and shifts in the pacemaker encountered. As has been noted many times in electroshock therapy, the postconvulsive period is often characterized by such electrocardiographic findings.[2,3] Certainly the tremendous muscular exercise attending the convulsion is sufficient to raise the blood pressure to levels where, upon cessation of muscle movement, gross reflex vagal effects should be noted, in accordance with Marey's law. Despite the obvious attenuation by succinylcholine of the convulsions caused by electroshock, there was always enough muscle contraction to account for the definite elevation in blood pressure noted during the postconvulsive period. This observation is attested by the postconvulsive tachycardia which, together with the rise in blood pressure, is characteristic of physical exercise. It is hard to assess the contribution of the asphyxia which in itself causes a rise in blood pressure and increased carbon dioxide to the degree of hypertension following electroshock. Surely, however, the exercise, with its resultant tachycardia and hypertension, is sufficient to explain the postconvulsive reflex vagal effects.

The presence of the bradycardia and shifting pacemaker, occasionally seen following the injection of succinylcholine but prior to the administration of electroshock, is not so clearly explained. We noted, however, that the patients who had the most pronounced vagotonia, as reflected electrocardiographically following electroshock, were usually the ones who were likely to show similar effects on the succinylcholine alone. Probably more instances of vagal effects in the preshock period would have been recorded if it were not for the fact that this period was always cut short (never lasting beyond 30 to 60 seconds) by the convulsive treatment. As succinylcholine appears to affect primarily the striated motor end plate and does not have much effect on ganglia except in large doses[1] and as drugs of this type usually do not possess a muscarinic action, direct effect on the heart does not appear likely, namely, production of "vagal effects." This view is supported by the time interval after the injection before bradycardia ensues. It seems to us that ordinarily there is enough muscle fasciculation, together with the evidently disagreeable sensation, to produce a rise in blood pressure. That such a rise in blood pressure occurs after succinylcholine injection is attested to by others.[4,5] If the blood pressure is sufficiently elevated, the same reflex vagotonia should occur as is seen in the postconvulsive period. Asphyxia commonly takes place for one to two minutes before elevation of blood pressure occurs, and in our cases such a lapse of time does not pass before electroshock.

That both the preshock and postshock cardiac effects are mediated by the vagus is supported by their prevention by atropine. In doses of approximately 1.2 mg. given subcutaneously approximately 30 minutes prior to treatment, this drug is almost completely effective. We have avoided its use intravenously immediately prior to treatment because of the possibility of the production of nodal rhythm on vagal stimulation during the treatment.[6] If it is given subcutaneously 30 minutes before treatment, the effect should be present at the sinoauricular node as well as the atrioventricular node, and the possibility of production of nodal rhythm by the atropine itself is avoided.

Another reason to believe that all the cardiac effects (except such effects as ventricular ectopic beats and bundle branch block) are reflex vagal in type rests on the influence of the oxygen administration and artificial respiration. Perhaps it is solely the thoracic movement, which causes changes in vagal tone secondary to pulmonary or great vein reflexes, that plays the major role in this phenomenon. The oxygen itself appears to lessen the production of ventricular ectopic beats and runs of ventricular tachycardia. Chlorpromazine has been mentioned as being useful in the prevention of extravagal arrhythmias, but we have had no experience with the drug in this regard.[5]

The question of the upright P wave with normal QRS, but short P-R interval, has recently been studied by Borduas, Rakita, Kennamer and Prinzmetal.[7] They mentioned that in their clinical experience and in their experiments variations in "vagosympathetic tone" did not generally produce the short P-R, upright P, complex. In our series, however, we noted several patients with this type of complex as a part of their change in "vagosympathetic tone" (fig. 2). Some of these

could be classified as examples of "accelerated conduction."[7]

Of considerable interest to us was the highly specific individual response of the patient to the vagal reflex. If the patient exhibited a particularly pronounced bradycardia, shift of the pacemaker of a particular type, or some type of block, it would almost always be reproduced during the next treatment unless atropine was used.

Summary

The use of succinylcholine to modify electroshock therapy provided an excellent clinical opportunity to study certain arrhythmias. These arrhythmias, with the exception of ventricular ectopic beats, appear to be entirely vagal in origin and can be abolished by atropine in doses of 1.2 mg. or greater, given subcutaneously about 30 minutes prior to electroshock treatment. We postulate a simple reflex vagotonia secondary to hypertension as a cause of the arrhythmias. After electroshock therapy, the hypertension produced by the convulsive effort appears entirely adequate to bring about reflex vagal activity. Immediately subsequent to succinylcholine injection, muscle fasciculation and associated apprehension may be sufficient to explain the hypertension, although a direct hypertensive effect of the drug itself is not ruled out. In any event, the blood pressure frequently rises after succinylcholine injection, and vagal arrhythmias ensue.

The relatively specific individual cardiac reaction to the vagotonia is mentioned, and examples of "accelerated conduction" due to variation in "vagosympathetic tone" are noted.

The use of atropine and adequate oxygenation are strongly recommended in succinylcholine-modified electroshock therapy.

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Discussion

DR. CLIFTON B. LEECH, Fort Lauderdale: Among the significant data presented are:

1. The high incidence of arrhythmias, vagal and extravagal.

2. The effectiveness of atropine in preventing the vagal disturbances. (It also prevents excessive secretion in the respiratory passages.)

3. The effectiveness of oxygen in abolishing extravagal cardiac irritability. In some clinics controlled respiration with 100 per cent oxygen by bag and mask is begun as soon as the patient has lost consciousness and is continued until spontaneous respiration is re-established in the post-stimulus recovery period.

Dr. Cooper's theory as to the cause of the paroxysmal hypertension which accompanies the fasciculations produced by succinylcholine, that is, the fasciculations themselves and in turn the production of reflex vagal activity, seems plausible.

In respect to the enhancing action of neostigmine on succinylcholine due to its inhibition of cholinesterase, which destroys the acetylcholine liberated at the vagal ends and thus encourages the vagus inhibiting effect, it may be noted that neostigmine alone, apparently by this action, is frequently effective in the abolishment and prophylaxis of supraventricular tachycardias.

The demonstration of accelerated conduction is consistent with the clinical and experimental studies which have shown that this phenomenon can be produced in animals and that the AV node can have three different types of disturbances: (a) heart block; (b) accelerated conduction; and (c) nodal rhythms and arrhythmias. It has been shown that dysfunction of the AV node may completely change the duration and configuration of the QRS complex.

The important practical application of data of this type is the amelioration of cardiovascular strain in patients with cardiovascular disease in whom electrotherapy for psychiatric illness has been somewhat restricted. In this connection technics including the use of additional drugs have been and are being investigated in various centers. Dr. Cooper has contributed importantly to this effort.

Annual Meeting

The Eighty-Third Annual Meeting of the Florida Medical Association is being held May 3-5, 1957 in the Hollywood Beach Hotel at Hollywood.

Surgical Jaundice

Ashbel C. Williams, M.D.
JACKSONVILLE

The problem of jaundice has become increasingly frequent because of the great rise in infectious hepatitis and homologous serum icterus which has taken place in the last 15 years.[1] This has brought about a corresponding increase in the need for diagnostic and therapeutic acumen on the part of the physician who cares for the icteric patient. Indeed, the survival of the patient not infrequently hinges upon the correct appraisal of the etiology of the jaundice for this information is essential to the proper selection of therapy.

Generally speaking, the first and often the greatest problem in the approach to a jaundiced patient is to determine whether his jaundice is "medical" or "surgical." "Medical" jaundice designates jaundice which is most often hepatic in its etiology and in which the mode of treatment is medical or nonoperative. "Surgical" jaundice, on the other hand, encompasses jaundice which is posthepatic or obstructive in origin and which is usually amenable to correction by surgery. Hemolytic or prehepatic jaundice may be medical or surgical, but since such cases are uncommon and have rather specific diagnostic criteria, discussion of this type of icterus will be omitted.

The scope of this paper will be limited to surgical jaundice of an obstructive nature. The various causes will be listed and observations made relative to the management of such cases.

Diagnosis

Before embarking upon this discussion of surgical jaundice, it is fitting to revert to the essential problem already mentioned, that of distinguishing in a given patient whether the jaundice is medical or surgical. In dealing with jaundiced patients, knowing what to do of course is paramount. Yet, it is scarcely less important to know what not to do, for to submit a patient with medical jaundice to surgery is not only useless, but is injurious and may even be fatal.

Zollinger and Williams[2] have recently published a most excellent paper presenting their experiences in the problem of differentiating surgical from medical jaundice. In a series of 207 cases in which a preliminary diagnosis of surgical jaundice was made, medical jaundice was found at operation in 6.4 per cent of the cases. Efforts to reduce this percentage of error led to the evolution of the "Jaundice Balance Sheet," a form listing the specific pertinent factors in the history, physical examination and laboratory findings which, when carefully weighed, will give a high degree of accuracy in differentiating medical and surgical jaundice. The chief value of the "Jaundice Balance Sheet" is that it insures that the essential significant diagnostic factors in the history, physical examination, and laboratory findings, respectively, will be ascertained and that they will all be considered in arriving at the diagnosis. The physician seeking a better grasp of the diagnostic aspects of surgical jaundice is referred to the studies of Zollinger and his associates.[2,5] He will find them most helpful.

Obstructive Surgical Jaundice Causes and Management

After one decides that a patient has surgical jaundice, the next step is to determine as nearly as possible the exact nature of the lesion so that the operative procedure can be anticipated. It has been shown that in about one of every two such patients, the biliary obstruction will be on the basis of a benign lesion (stone, ductal stricture). In about one of every three such patients the obstruction is due to malignant disease primary in the biliary system or pancreas, or metastatic.[4]

Jaundice in infancy may also be surgical, namely, that due to congenital atresia of the bile ducts. Such atresia may be limited to a segment of the common bile duct, a most favorable situation. More often it may involve the entire biliary tree or any combination of its components. In cases of this type the liver is enlarged. Since the obstruction is complete, acholic stools are present, and the urine is stained with bile pigment from birth. Jaundice, light at first, becomes pronounced by the third week of life and persists at a fairly constant level thereafter. If, after application of the various medical and therapeutic measures for a period of six weeks, there is no clearing of the jaundice, atresia of the bile ducts should be suspected and surgical exploration undertaken.

Read before the Northeast Medical District Meeting, Gainesville, Oct. 12, 1955. Published with additions.

Gross[6] reported that in 146 patients found at operation to have biliary atresia, 27 had patent ductal remnants, and in 12 a successful anastomosis was performed between this remnant and the bowel. Such a possibility must always be considered when one deals with jaundice in infancy.

Benign Obstructing Lesions

By far the most common benign obstructing lesion causing jaundice is choledocholithiasis. It is the cause of icterus in nearly 50 per cent of adults with surgical jaundice.[4] Because of the relative frequency of occurrence of this lesion it will be considered at some length.

Careful questioning will bring out an antecedent history of cholecystitis in 70 per cent of the cases.[4] About six out of 10 patients will have or have had chills and fever.[4] Nausea and vomiting will occur in over 80 per cent of cases in which there is distention of the common duct due to calculus obstruction.[3,4] Pain, usually present, is not essential to the diagnosis of common duct stone. Loss of weight, thought to be typical of obstruction due to malignant disease, is also typical of calculus cases of long standing.

The urine will be stained with bile, but will not show urobilinogen if obstruction is complete. Liver function tests should be normal unless the obstruction is of long duration (three weeks plus). The alkaline phosphatase is elevated. The icteric index and serum bilirubin are markedly elevated. Duodenal drainage will probably show crystals if the obstruction is of calculus etiology. Radiographic films of the abdomen may show the offending stone.

Of interest in this connection is an analysis by Zollinger and Britt[4] of 100 cases in which common duct stones were recovered at operation. He found that 44 per cent of the patients were jaundiced at the time of surgery while 21 per cent gave a past history of jaundice. In 35 per cent of this group there was no history of jaundice past or present. There was an associated acute cholecystitis in 10 per cent of these cases. The mortality for cholecystectomy and choledochostomy was 4 per cent in this series.

Also pertinent to this discussion is the problem of whether or not to explore the common bile duct for possible stones at the time of cholecystectomy. There is some variance in the indications for such exploration and considerable variance in the results. Colcock[7] reported that at the Lahey Clinic common duct exploration is carried out in conjunction with cholecystectomy in about 45 per cent of the cases. Stones were found in 36.7 per cent of the ducts explored and in 16 per cent of all patients undergoing cholecystectomy. No untoward results have been experienced at the Lahey Clinic from exploration of the common duct.

At the Lahey Clinic the following are regarded as the indications for exploration of the common bile duct: (1) the presence or history of jaundice, (2) a dilated or thickened common duct, (3) the presence of small stones in the gallbladder, (4) positive or suspicious findings on palpation of the common duct, (5) sediment in the bile aspirated from the common duct, (6) acute or subacute pancreatitis, and (7) a noncalculous gallbladder with biliary tract symptoms such as colic.[7]

Glenn,[8] having a more conservative attitude toward choledochostomy, explored the common duct for suspected stones in conjunction with 10.5 per cent of cholecystectomies. Stones were found in 69.1 per cent of the ducts so explored, or 7.2 per cent of the entire group undergoing cholecystectomy.

Technically, it is often difficult to locate an obstructing common duct calculus because of the accompanying inflammatory reaction or because the stone may be in the distal reaches of the duct where it cannot be palpated. In such cases, if a probe cannot be threaded down the duct into the duodenum, the duodenum should be opened, the ampulla of Vater identified and the duct explored in a retrograde manner. This maneuver will often reveal a stone impacted in the ampulla of Vater which could not have been located or dislodged otherwise.

Also, it is here perhaps that operative cholangiography finds its greatest field of usefulness.[9] It may reveal unsuspected stones in the hepatic ducts or overlooked stones in the common duct. If negative, it gives one the satisfaction of knowing that the ductal system is clear of stones. It is used also to demonstrate the proper placement and patency of the T-tube before the abdomen is closed. Many writers have advised routine employment of operative cholangiograms in choledochostomies. This concept, though logical and well founded, has practical disadvantages (added expense and added operating time) which have hindered its widespread adoption. It should be obvious, however, that every surgeon and every hospital in which biliary surgery is performed

should be familiar with and equipped to carry out operative cholangiography.

If one has explored and drained the common bile duct and has not taken an operative cholangiogram, it is wise to visualize the ductal system before removing the T-tube. This, of course, is done by instilling the contrast medium through the T-tube and will give a clear picture of the current status of the biliary ducts. Should jaundice, or other symptoms indicative of possible ductal disease, appear at a future date, the surgeon may draw considerable comfort from the fact that he can exhibit a normal cholangiogram made at or shortly after operation.

The recently developed intravenous cholangiogram has provided a means of studying the ductal system of patients who have had cholecystectomy and who have no drainage tube in the common bile duct. If obstruction of the duct is total, there may be no visualization of the biliary system. Larger stones in the ducts should be visualized. The intravenous cholangiogram perhaps is most useful in a negative manner. If normal, it rules out obstruction of the ducts and gross intraductal lesions. If the ducts are not visualized, one is left to ponder whether there is disturbed liver function or complete ductal obstruction, or whether the patient's common duct has extruded the dye into the bowel before the films were taken. Intravenous cholangiograms are contraindicated in the presence of jaundice.[10]

Strictures of the common bile duct present great difficulties, sometimes in their diagnosis, always in their treatment.[11] Fortunately, they are found in less than 10 per cent of the patients with surgical jaundice.[4] Nearly all benign strictures are due to previous biliary surgery.[11] Should jaundice develop shortly after cholecystectomy, a common duct injury is the most likely explanation. This is especially true if there was troublesome hemorrhage or difficulty in obtaining adequate exposure at surgery.

There are two rules of thumb in connection with biliary surgery which, if observed, should prevent common duct injury. First, as was often pointed out by Dr. Frank Lahey, when one performs cholecystectomy, the cystic duct should never be clamped and divided until it has been dissected cleanly down to the common bile duct and the angle between the cystic duct and common duct clearly visualized. Second, occasionally profuse hemorrhage will be encountered due to escape of the cystic artery or laceration of the portal vein, which hemorrhage defies the usual measure of control. In such a situation it is wise not to persist in trying to control the hemorrhage with clamps. It is most dangerous to apply clamps in this area when exposure and visibility are not adequate as is the case in uncontrolled bleeding. In three such instances I have succeeded in controlling the hemorrhage by packing the wound firmly with large roller gauze packs or laparotomy pads, exerting manual pressure over the bleeding area for 15 or 20 minutes and then closing the wound with the packs still in place. They can be safely removed on the third postoperative day. There is considerable serosanguinous drainage while the packs are in place, but they will usually control active hemorrhage. No hernias have been noted postoperatively in the three cases mentioned.

Finally, should the surgeon become aware at the time of operation that the common duct has been injured, it is best to perform an immediate repair, preferably by an end to end anastomosis of the duct. Should this not be possible, the proximal end of the duct should be implanted in the jejunum. Repair at this time should be easier and more prone to success than if made at a later operation.

Most often common duct injury is not suspected until the patient becomes jaundiced. The repair of an injured common bile duct is one of the most difficult operations with which the surgeon may be confronted. Unless he has had some considerable experience with this specific problem. it is advisable to refer the patient elsewhere for the operative repair. Even in the hands of those who have been dealing with these problem cases for years the results leave much to be desired.[11] In these secondary operations an effort is made to locate and anastomose the proximal and distal ends of the ducts.[11] Failing this, the proximal end of the duct should be implanted in the jejunum and an enteroenterostomy performed to minimize the chances of reflux cholangitis. Ductal anastomoses are always done over T-tubes and the tubes left in for several months. The T-tube should be implanted in the common duct above or below the anastomosis with a horizontal limb of the tube extending through the anastomosis.[7] This procedure minimizes the chances of stricture at the anastomosis.

Malignant Obstructing Lesions

Attention is next directed to the group of patients with surgical jaundice in which the obstructing lesion is malignant. This group, as has

been noted, makes up about one third of the patients with surgical jaundice. Zollinger[4] found that of 34 patients with obstruction due to malignant disease 21 patients had carcinoma of the ampulla of Vater or of the pancreas, 10 patients had carcinoma primary in the bile duct, and in three patients, the obstruction was caused by carcinoma metastatic from elsewhere in the gastrointestinal tract.

A dilated palpable gallbladder may occur with any of these lesions and is present in about 50 per cent of such cases in conjunction with jaundice (Courvoisier's law). Painless jaundice is often the first sign of carcinoma of the ampulla of Vater.[12] Colicky pain of a biliary nature due to obstruction of the bile duct appears later. In carcinoma of the pancreas, pain is often the first symptom. It is epigastric in location and typically radiates through to the back. Loss of appetite and weight often occurs in both lesions. Blood in the stool in the presence of jaundice is highly suggestive of a malignant lesion of the ampulla of Vater or of the pancreas. Blood found in duodenal drainage is diagnostic of tumor in this area. Cytologic studies of the duodenal washings may show cancer cells and thus prove the diagnosis of tumor.[12]

Most often it is only at surgical exploration that diagnosis of malignant disease is confirmed, its primary site ascertained and its resectability determined. These questions are not easily answered even at surgery. Vaterian lesions can be visualized by means of an operative cholangiogram. They can nearly always be palpated by incision of the duodenum. They must be biopsied directly for diagnosis as metastatic nodes are not usually available. If they are resectable, the proper surgery consists of resection of the distal portion of the common duct, adjacent duodenum and head of the pancreas in continuity. Gastrojejunostomy, choledochojejunostomy and pancreaticojejunostomy are then performed. This operation carries a mortality of about 25 per cent in good hands. The five year survivals are up to 25 per cent. One is encouraged to attempt surgical extirpation and cure of these lesions because they so often remain localized and do not metastasize widely. If there is reasonable doubt as to the resectability of the lesion, a cholecystojejunostomy for palliation is the wisest choice.

At operation lesions of the pancreas are usually palpable if they have been symptomatic. Biopsy of the pancreatic mass is notoriously inaccurate. Biopsy of the nodes adjacent to the pancreas, on the other hand, will yield a positive diagnosis in about 85 per cent of the cases in which carcinoma is present.[12] Because of this propensity of pancreatic carcinoma to metastasize early to multiple lymph nodes, the five year survival rate is extremely low. Only the small and early pancreatic lesions deserve resection. The same operation is performed here as for vaterian carcinoma except that the entire pancreas may be removed, depending on the size and location of the tumor in the pancreas. Should the lesion be advanced at all, a palliative cholecystojejunostomy is best. It has been shown that radical surgery does not cure or prolong life unless these lesions are truly small and early.[13] This is the consensus of those having wide experience in this field.[14,15] One notable dissenter is Dr. Alexander Brunschwig, who at a recent meeting reported five year survivals in 12 cases of carcinoma of the ampulla of Vater and 13 cases of carcinoma of the pancreas.[16] He believes in making an all out attempt at surgical cure in all but the obviously advanced cases.

The reason for the discouraging results in cancer of the pancreas is to be found in a study by Mikal and Campbell,[17] who reported that of 100 cases of carcinoma of the pancreas subjected to autopsy, in only 20 was there freedom from metastases. On the other hand, in a series of 110 autopsied cases of carcinoma of the ampulla of Vater the tumor was limited to the ampulla in 82 per cent.[12]

Obstruction of the common duct secondary to metastatic carcinoma follows such an unpredictable pattern that little can be gleaned from a consideration of such lesions.

In general, the indications for surgery in patients with jaundice are: (1) a history of gallstones, (2) proved intermittent or complete biliary obstruction, and (3) the presence of a biliary fistula. The contraindications to surgery in the jaundiced patient are: (1) a history of a recent transfusion (not absolute), (2) the presence of vascular spiders, edema and evidence of collateral circulation, (3) intense jaundice in the presence of patent bile ducts and disturbed liver function, and (4) a prolonged prothrombin time not responding to vitamin K.[1]

The careful preoperative preparation of the jaundiced patient for surgery is extremely important to give the best assurance of success. The blood proteins, red blood cell count and hemoglobin should be brought up to a normal range. Intravenous fluids with added glucose are given along with a diet high in protein and carbohy-

drate. Fats are badly needed and should be fed the patient in as large a quantity as he will tolerate. The prothrombin time, if prolonged, must be brought to normal by the administration of vitamin K intramuscularly. Large doses of vitamins C and B should be given parenterally and crude liver extract injected intramuscularly for several days preoperatively. If the patient has fever and/or chills, antibiotics are an essential element in the preparation for surgery.[4]

Discussion

In this paper an effort has been made to present a summary of the essentials of surgical jaundice. As noted, space does not permit including all types of surgical jaundice in the presentation. Many of the less essential details have of necessity been omitted. Especially is this true in the field of the laboratory studies relative to the determination of liver function since such studies tend to fall into the field of the internist or gastroenterologist. The surgeon must nevertheless possess a thorough understanding of the use and interpretation of these various tests.

It should be brought out that in many of these problem cases it is advisable to wait as long as two to three weeks, repeating the various laboratory determinations and observing the patient carefully before deciding whether the case is medical or surgical. Waiting beyond this period is not advisable for, if obstruction of the common duct is present, the patient's condition begins to deteriorate and his liver function tests may show liver damage on an obstructive basis, thus leading to more confusion.[2]

There will be disappointments no matter how careful and how skillful the management of these jaundiced patients may be. On the other hand, there are few situations in medicine which can yield a greater satisfaction to the patient and to the physician than that of the successful definitive relief of obstructive jaundice.

Summary

"Surgical jaundice" is defined and the various causative lesions outlined.

The importance of distinguishing between medical and surgical jaundice is stressed.

The diagnosis and management of benign lesions causing obstruction of the common bile duct are discussed, emphasis being accorded calculus obstruction.

Pertinent observations are made relative to the recognition and surgical handling of malignant lesions of the ampulla of Vater and pancreas.

The indications for and contraindications to surgery in jaundiced patients are outlined.

The importance of preoperative preparation of jaundiced patients is noted, and the essential preparatory measures are listed.

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Application of Plastic Surgery Principles In Early Management of Severe Facial Injuries

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Early proper care of a facial injury will give a better final result in a single operation than can be obtained even by numerous plastic procedures at later dates. Prompt treatment will lessen infection, fibrosis, bone fixation in malposition and distortion of soft tissues and features. The policy of or the necessity of awaiting subsidence of swelling prior to repair may be detrimental and may necessitate extensive secondary correction.

Prior to operation on severe facial injuries a general evaluation of the patient is carried out, especially as to shock, cerebral injury, cervical spine injury, ocular damage or intoxication, any of which may warrant some delay in repairing the face. Internal injuries or other fractures may take priority in care. The patient should have a neurologic evaluation and roentgen examination of the cervical spine when indicated, as in the instance of a "snap" type of injury to the head. Repair the facial injury at the earliest time the general condition allows. Only directional closure may be performed at times, but the wounds should not be packed open for any length of time, nor the features left out of place. The best chance for the best repair is the earliest one possible.

After careful examination the findings are recorded before operation as to any tissues lost, vision and seventh nerve action as these elements will affect the final result. Additional information is gained after cleansing and anesthetizing, and by further determination of the extent of injury. A thorough search is made for facial fractures by palpation; careful check is also made of the occlusion of the teeth and of the patency of the nasal passages. With all possible information at hand an over-all plan for the repair is formulated.

This report represents the current methods used on our plastic surgery service in the handling of traumatized soft tissue and fractures in severe facial injuries. Throughout this report, the vital importance of proper early therapy is stressed.

Roentgen Examination

When it is believed to be safe for the patient, roentgenograms of the involved regions are made before operation, but because of superimposition of facial bones, roentgen study may not give as much information as one might hope for. Roentgenograms of the mandible should include lateral views of both sides and the posterior-anterior view; when necessary, laminographs may be taken to show the temporomandibular joint area. A view from the modified Waters position will show the orbital rims and the zygoma, and will reveal clouding of the antrum. A basal view will show the zygomatic arches. Lateral exposure, with a dental film against the side of the nose, will give the best information of the nasal bones. When indicated, skull and cervical spine series are taken.

Fractures

Fractures are usually reduced and fixed first to make the patient more comfortable and to facilitate a soft tissue repair. After fracture fixation, further cleansing of the wounds is done, and fresh drapes and gloves are used for closure of soft tissue. With facial fractures, as with lacerations, early operation gives the best results. If one waits for the subsidence of swelling, the best period for repair is lost. There may be widespread soft tissue injury without fracture, and contrariwise, numerous comminuted fractures may occur without skin lacerations. In most accidents bone and soft tissue injury occurs together and is repaired at the same time. Marked comminution of the thin bones of the face may occur with possibly 75 to 100 fractures in a severe injury, as the face seems literally to be "exploded." Basically, we undo what the accident did, return the tissues to their normal position and fix them in place.

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If operation has to be delayed because of the general condition, effort is made to reduce the fractures within at least ten days. Otherwise early fixation of bone fragments out of place, with swelling, hemorrhage and fibrosis, may make later, proper reduction and fixation difficult or impossible.

Conservatism is the rule when dealing with numerous, loose bone chips because important support may be lost by discarding fragments which might live and contribute to stability. By this conservative plan for bone fragments the need for bone grafts may be avoided. Even though it may be necessary at times to remove some dead fragments later, this conservative policy is followed. Fragments are replaced and maintained in position with minimal manipulation, avoiding complicated splints and traction devices whenever possible.

Internal wire pins are a valuable means of stabilization, after alignment, of fractures at the time of primary repair. Small comminuted bones, in the nose or maxilla, are molded in position and held in place by gauze packs. Thin platelike bones of the face may never heal by bony union, but functional results and normal contour anatomy are obtained by a fibrous bridging.

The sequence of repair is important, almost always aligning and fixing the bones first. The patient is made more comfortable by fixation of bony fragments under local anesthesia, and following this procedure, the soft tissue damage is repaired. A fracture of the symphysis of the mandible, for instance, causes particular discomfort and stabilizing it may facilitate other repairs.

Mandible

The simplest method of stabilization of a fractured mandible is by interdental wire fixation to the upper jaw, if adequate teeth are present, using No. 24 stainless steel wire. The bicuspid teeth are used oftenest, but other teeth may be wired, with wires anterior and posterior to the fracture when possible. If the patient is intoxicated, is an epileptic, or has questionable cerebral damage, the jaws should not be wired together because of the danger of aspiration. Steel arch bars of various types fixed to individual teeth are of value in some fractures, such as of the symphysis, and this measure is usually combined with interdental wiring in order still to use the opposite jaw for stability. A simple device is to twist wires on molar teeth clear out of the mouth and then close them as an arch with anchors to various teeth.

Internal wire pin fixation, alone or in combination with interdental or circumferential wiring, is of the greatest value with extensive comminution, if treatment has been delayed, in areas where union is apt to be poor, such as at the symphysis, in an edentulous mandible, or with fractures behind available teeth near the angle of the jaw. With the mandible shattered into

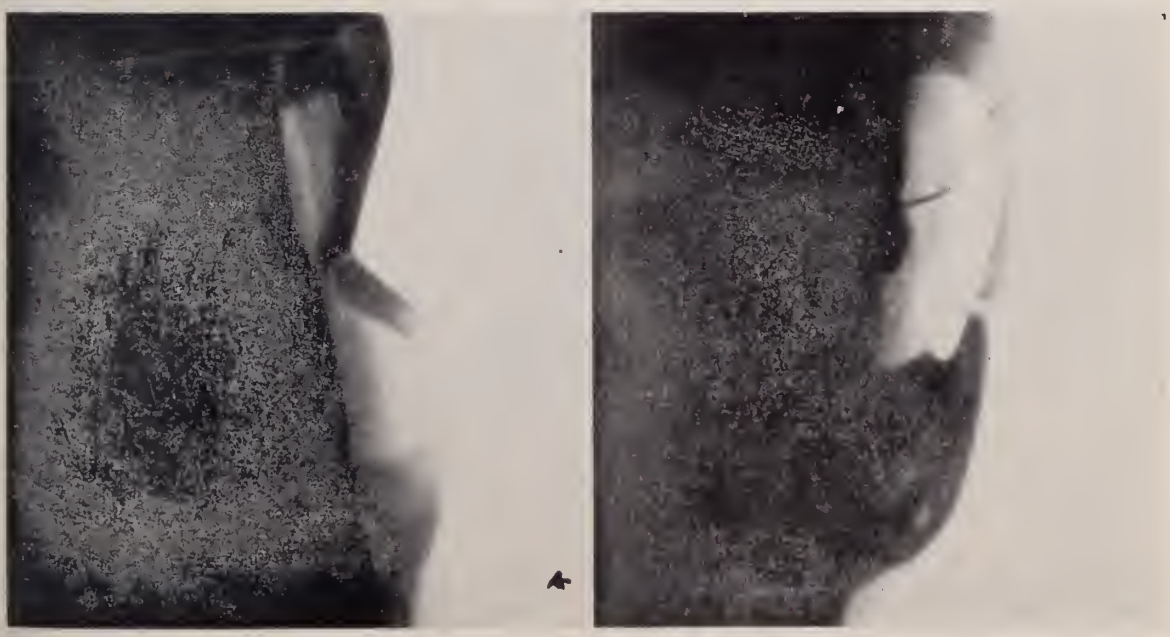

Fig. 1. — Roentgenograms showing a depressed fracture of the zygomatic arch. Free movement of the mandible is prevented by impingement of the coronoid process. An elevator may be passed beneath the temporalis fascia and arch to elevate the fracture. Direct hook elevation is generally used.

Fig. 2. — Widespread avulsion and shattering of the face in an automobile accident. Bones were shattered into many small fragments. Fixation was accomplished with cross wires for the nose, direct wiring of the zygoma and iodoform gauze splinting of the antrums. Two internal wires were placed across shattered fragments on both sides for stabilization. Only one operation was necessary. (Brown, J. B.; Fryer, M. P., and McDowell, F.: Internal Wire-Pin Stabilization for Middle Third Facial Fracture, Surg., Gynec. & Obst. 93:676-681, Dec. 1951.)

numerous fragments, alignment and fixation of larger fragments, mulching smaller fragments in position and prolonged fixation will give a solid, functioning mandible and avoid the necessity of secondary bone grafts. By pin fixation in patients with loss of a portion of the mandible, undue contraction of soft tissue is prevented. This method can also be combined with fixation to the upper

jaw, but this often can be opened at an early date, and the patient can eat during the period of immobilization. A stainless steel pin is used, or various-sized Kirschner wires, generally of .062 gauge, preferably sharpened to a bayonet point.

The fractured mandible is manually reduced and held in position while a Kirschner wire is driven across the fracture site, below the tooth roots and inferior alveolar nerve. Only rarely is direct bone wiring or circumferential wiring of the jaw necessary. A small dependent drain usually is placed at the fracture site, especially if there has been much displacement or manipulation. Large doses of antibiotics are given. The period of fixation varies from three weeks for fracture of the condyle, coronoid or ramus to six weeks for fracture of the body. If severely comminuted, or if infection develops, the mandible may be immobilized even two months or longer, the wire pins making this period of immobilization possible and more comfortable than only interdental wiring.

In children especially, a careful history is taken and findings noted. For example, if a child has been struck on his chin directly, a thorough search should be made for condylar fracture, as the neck is easily snapped off. Such a situation has the attendant danger of late ankylosis.

A mandibular fracture line may persist on the roentgenogram despite solid bony healing, a significant feature from the prognostic and medicolegal standpoint.

Orbit-Zygoma

The simplest method of reduction of a fractured zygoma is by direct hook elevation, through the cheek under the bone. If the fragments impact in position, no further treatment is necessary. If unstable, the antrum is entered through a buccal fornix incision, or in through the fracture line that is always present in crushes, the clot is evacuated, the antral wall and orbital floor are molded in place with a blunt elevator, and the comminuted parts are held in position with a balsam of Peru-iodoform pack placed in the antrum.

By use of an internal wire, the opposite sound zygoma may be used as a point of fixation; the pin is driven across through the nose with an electric motor and picks up the replaced zygoma, holding it in position by cantilever action. This pin may be used as a second point of fixation. With displacement and instability of the zygoma of considerable degree, direct wiring may be used to fix the ascending ramus to the frontal bone.

In general, the zygoma, orbital borders and antrum are considered as a unit, since in displacement of the zygoma, the orbital border is lowered and the antrum is crumpled.

A depressed zygomatic arch can be lifted outward by means of a heavy hook. At times the approach of Gillies is used, wherein an incision through the temporalis fascia allows an elevator to slip medial to the arch for elevation.

Maxilla

To stabilize a fracture of the upper jaw, interdental wire fixation to the mandible is generally used, the same as the maxilla is used to splint the mandible. A Risdon arch bar on the teeth is often of help to give another plane of fixation. Wire pins may be driven from solid to loose portions of the maxilla, this procedure being of special value in an edentulous upper jaw or in alveolar fractures. In some instances, the zygoma may be used as a stable point for wire fixation of a loose fragment. At times, even though both jaws may be fractured, they can be reduced into normal occlusion to assist in supporting each other.

With trauma from below, the antrum is crumpled upward, and the upper jaw must be reduced downward prior to any fixation by one of the methods described.

In almost all mid-third facial fractures the lacrimal duct will be displaced or torn, and if it is permanently obstructed, this condition may lead to severe sequelae. With early reduction, healing is generally satisfactory, and rarely ever is the lacrimal duct permanently blocked.

Nose

Depression of the nasal bones is corrected by bringing the nose forward with rubber-covered Kelly forceps. With depressed fractures, the crumpled nasal septum is straightened out if possible at the time the nasal bridge is raised. A long nasal speculum is of value in restoring septal position and assuring a patent airway . Lateral spreading or lateral deviation of the bony walls is corrected by digital pressure. If extremely unstable, the bridge may be held up with wire sutures through the nasal walls and septum, traversing the fracture lines and fastened over thin lead plates on each side of the nose, to distribute the support and not cut into the skin. At times a wire may be passed into the mouth and fastened to an opposite bicuspid tooth to aid alignment. Adequate elevation and fixation of the nose help to restore proper position of displaced canthi.

Fig. 3. — Complete restoration in extensive soft tissue injury with complete separation through the symphysis. A single operative procedure was carried out a few hours after the accident. Internal wire pin fixation is of the greatest value in this type of fracture.

After reduction, the nose is gently packed with iodoform gauze to maintain an airway and hold the mucosal flaps in place. To hold the nasal bones in position, an aluminum splint, shaped to the nose, is used for about 10 days.

It is especially important to secure accurate reduction of infant and childhood nasal injuries, as these will often show progressing deformity during growth. Early reduction and fixation may prevent some developmental deformities, but the parents should always be told of the possible results, even if an early repair has been made.

Soft Tissue Repair

Wounds are gently and thoroughly cleansed with mild soap or detergent and copiously irrigated with saline. All dirt ground into the wound is meticulously removed by scrubbing or using a scalpel if necessary, to avoid an unsightly traumatic tatoo. A solvent, as ether or benzine, may be used to remove grease or oil. Small pieces of glass are easily overlooked and are carefully searched for, certainly if there was a history of broken glass at the accident. Hemostasis is vitally important, as a hematoma may compromise an otherwise excellent result. Rarely will it be helpful or necessary to ligate the external carotid artery to control bleeding.

The eyebrows should not be shaved prior to repair. They do not materially compromise sterility and may well assist in repair by serving as an important landmark. Several months may be required for the regrowth of the eyebrows, conjunctivitis may develop, and the appearance is awkward.

For the least discomfort to the patient, avoid any manipulation until the patient is in the operating room, unless it is a necessity to assure the airway, as in holding the jaw forward. As to the problem of when to anesthetize, cleansing is generally carried out in a gentle manner until it becomes too uncomfortable, after which the local anesthetic is applied and the cleansing completed. If a general anesthetic is to be used, cleansing may be delayed until the patient is anesthetized.

General anesthesia should be avoided if possible in facial injuries, but it may be necessary in children and in some adults, given by the endotracheal route. Local anesthesia with Novocain usually is adequate when used with a basal anesthetic. A deep block of the maxillary and mandibular division of the trigeminal nerve is most helpful. In some cases, local infiltration, with topical application to the mucosal surface or in the wound, will be adequate.

Debridement of the facial tissues should be kept at a minimum, the basic rule being that it is far better to retain some tissue which may die than to remove any which may survive. Damaged skin which may even have a deep bluish appearance might still survive, with gentle treatment, either as a flap or free graft. Since gas gangrene is almost unknown in facial wounds, no extensive cutting debridement is necessary and primary closure may be carried out even in deep wounds. Since there is generally no extra tissue in the face, especially in a young person, cutting debridement may result in distortion of eyelids, nose and mouth, and the normal mobility and expression of the face may even be lost. Especially ragged, irregular wound edges can be cleanly and conservatively excised prior to accurate apposition. Open packing of a wound may uselessly necessitate many additional reparative procedures. Basically, save tissues and one will save features and function.

It is fortunate that facial nerve function is seldom permanently destroyed with trauma. But if it is apparent that a branch or the trunk of the nerve is cut, the ideal treatment is immediate repair. This may not be possible in all instances, especially if the treatment has been delayed and much swelling or infection supervenes. With the good chance of recovery of smaller branches, it may be said that this treatment might give the patient the best chance of function, rather than an extensive dissection.

Wounds are closed with deep or subcuticular sutures of fine catgut or white silk to take all tension off surface stitches. Waxed 7-0 black silk sutures on fine curved cutting needles are applied close to the edge of the wound, merely to support and adjust skin edges in accurate apposition. Multiple sutures tied loosely are relied on for the best results. Should heavy sutures be used for wound closure or if the sutures are placed far from the wound edge, typical "ladder" scars will result, which are difficult to eradicate without tissue sacrifice and possible feature distortion.

Fig. 4. — A. Roentgenogram showing a compound, comminuted fracture of the mandible, separation of fragments and inadequate teeth for fixation.

B., D. Reduction and internal wire pin fixation. The available teeth were used for additional fixation by interdental wiring.

C. Interdental wires were removed at four weeks to allow normal eating. Pins were removed six weeks later. (Fryer, M. P., and Brown, J. B.: Multiple Internal Wire Fixation of Facial Fractures, Am. J. Surg. 89:814-818, April 1955.)

Fig. 5. — Roentgenogram of wire pins in the face stabilizing fractured and dislocated zygomas. Smaller fragments are mulched in position and there are packs in both antrums. The nose is held by a wire sling, anchored to lead plates on the sides.

Heavy crushing forceps should not be used on the skin. Stay sutures are avoided when possible; however, if it is necessary to use a wide suture, they should be applied from the inside of the mouth or nose when feasible. When on the surface, stay sutures should be tied over gauze sponges or through adhesive-protected skin and removed early to avoid wide scarring.

In suturing wounds of the face one can best begin at a known landmark, such as the border of the lip, tarsus, eyebrow or nostril. If no landmark is present, the laceration is closed at the center and the remaining defect bisected with sutures until closed. Special care should be taken with the "trap-door" type of lacerations, closing "V" lacerations as "V's" and "Y's" as "Y's" and not vice versa. In the "trap-door" lacerations, the patient should be forewarned of the possibility of secondary repair being necessary.

When tissue is lost in facial trauma, care should be taken that features are not distorted by any forced closure. Wounds may be partially closed, or at times a free graft may be immediately applied. On occasions, with soft tissue loss, judicious use of internal pins will be invaluable to maintain position of bony fragments. By avoiding wound collapse and facial distortion in repair, less extensive secondary procedures will be necessary.

At times, the question of using a totally detached piece of tissue or feature will arise. Save for a rare exception, these measures will not be successful, but undue criticism may be avoided by attempting such usage.

Summary

In repairing facial injuries one should always bear in mind to strive for proper lid closure and bony support to protect and maintain position of the eyes; for patency of the nasal passages for breathing; for proper dental occlusion for chewing; and just as important, for restoration of normal contour anatomy so that the patient may have a stable educational, economic and social outlook. Special care must be given to overcome the serious psychic reaction which often follows a facial injury or else the most satisfactory repair will be compromised. Anxiety as to permanent disfigurement is a natural reaction, and honest, guarded advice as to what can be done will do much to relieve the distress of the patient and family.

Any extensive facial injury, regardless of the primary treatment, may need secondary plastic revisions to secure the optimum result, and this probability should be discussed with those concerned at the time the patient is first seen. Secondary procedures should not be rushed into, but allow a maximum period for the best possible healing and organization to occur. A far lesser number of secondary procedures will be necessary and the end results far more satisfactory if a careful, early, primary facial repair is carried out.

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Surgery Repeated for Recurrent Gallstone Ileus

Review of Literature and Report of Case

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Obturator obstruction of the small intestine by gallstones is a rare, yet an old, subject. Bartholin[1] is generally credited with publishing in 1654 the first case of a gallstone perforating from the gallbladder into the jejunum and producing so-called gallstone ileus. By 1890 Courvoisier[2] had collected from the literature and from personal experience enough material to publish a book outlining the surgical therapy for gallstone ileus. In 1943, Hand and Gilmore[3] collected 12,153 cases of intestinal obstruction, in 208 of which the cause was gallstones, an incidence of 1.7 per cent. In 1952, Milch, Mendez and Murphy[4] compiled 217 cases of complete intestinal obstruction over a five year period. In eight, or 3.6 per cent, of these cases the obstruction was due to gallstones. These figures are fairly in accord with the reports of most authors, who estimate the incidence at 1 to 2.5 per cent. In 1953, Wright and Trafford[5] reviewed the subject to that date and found a total number of around 600 cases of intestinal obstruction due to gallstones.

Gallstone Ileus: Incidence and Mortality

The majority of patients suffering from gallstone ileus are women in their fifth decade. Wortman,[6] however, reported a case of intestinal obstruction due to a gallstone in a 25 year old woman. In the available literature the patient of Lee,[7] in whom recurrent obstruction developed at the age of 87, was the oldest. The ratio of men to women is usually about 1:4. Kommerell,[8] in 1938, reviewed 127 collected cases of gallstone ileus in which 34 patients were men, a ratio of almost 1:4. Wangensteen[9] reported that gallstone obstruction occurs three times more frequently in women than in men, this ratio being a logical deduction from the more frequent occurrence of gallstones in women.

In 1890, Courvoisier[2] reported a 46 per cent mortality. Naunyn,[1] in 1892, after observing only one survival among 13 patients subjected to surgery for gallstone ileus, concluded that surgery was not to be recommended for such obstruction. He furthermore reported that 44 per cent of his patients treated conservatively without surgery recovered. Martin[1] reported a 69 per cent mortality in 1910. In 1930, Lutterotti[10] reported the mortality in two separate series of cases of gallstone ileus as 64 and 56 per cent. This high mortality often may have been a result of the advanced age of the patients with accompanying pulmonary and cardiovascular diseases plus an unwise postponement of surgery. The latter may frequently be due to the uncertain diagnosis, which is undoubtedly the most important factor affecting the mortality. In 1952, Milch and his associates[4] reported eight cases of gallstone obstruction with a 12.5 per cent mortality. In 1955, Deckoff,[11] in an excellent paper covering all aspects of gallstone ileus, collected 12 cases in an 11 year period with a mortality of 7.1 per cent.

Pathologic Process

A stone usually must be larger than 2.5 cm. to produce obstruction of the small intestine, for smaller stones will as a rule pass through the ileocecal valve. Wangensteen[9] mentioned two patients with small stones and some degree of spastic obstruction treated conservatively, who passed gallstones in the stool and recovered. The largest recorded stone to produce an obstruction was removed successfully from the transverse colon of an 81 year old man by Turner.[12] This stone measured 6 by 7 by 17 cm. Apparently it had eroded from the gallbladder into the adjacent colon, where it became impacted.

In the majority of cases stones reach the intestine through a fistula, and it is proper to consider gallstone ileus as a complication of internal biliary fistula. Inflammatory reaction causes the gallbladder to adhere to some portion of the gastrointestinal tract. The distended, inflamed

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gallbladder becomes attached to and then perforates into the adjacent hollow organ, and a fistula ensues. As the inflammation subsides, fibrosis develops, producing contracture of the gallbladder, which pushes the stone through the fistula. Some authorities believe that infection need not be present, but that a fistula may develop merely from pressure of the stone producing necrosis. Brewer[13] stated emphatically that before cholecystoduodenal fistula develops, there first must be a common duct stone producing obstruction. To support this opinion he presented an autopsy finding of a large common duct stone impacted in the ampulla of Vater, which had perforated through the right wall of the telescoped ductus choledochus. This theory has not been substantiated by the history of most patients who have had gallstone ileus, for rarely has associated jaundice or colicky pain been mentioned in the cases reported.

Courvoisier[2] observed that cholecystoduodenal fistula most commonly occurs between the posterior surface of the neck or fundus of the gallbladder and the first part of the duodenum, the portion so often bile-stained at autopsy. In seven out of 35 cases in his series, however, he thought that the stones passed into the small intestine by way of the common duct and then caused obstruction. One of these stones was reported to be 10 cm. in size. Morgagni[1] reported a case in which the common duct was dilated to the size of the stomach and was full of stones. Holz[14] cited Wortmann[6] as having seen a walnut-sized stone which passed through the common duct. At laparotomy the stone was found impacted 20 cm. above the ileocecal valve. The patient died, and at postmortem examination a hole the size of a two pence piece was found in the duodenum corresponding to the ampulla of Vater. Two additional stones were found in the common duct.

Wakefield, Vickers and Walters[15] reported that in 176 cases of cholecystoenteric fistula, perforation involved the gallbladder and duodenum in 101 cases, the gallbladder and colon in 33 cases, and the gallbladder and stomach in seven cases. In 24 cases stones were discharged into the abdominal cavity; in 11 cases there were multiple perforations between the gallbladder and adjacent organs. Intestinal obstruction, however, occurred in only 10 per cent of the cases in which stones perforated into the gastrointestinal tract. Martin[1] mentioned the passing of a stone into the ureter by way of a perinephritic abscess secondary to acute cholecystitis. It descended the ureter and was found in the urinary bladder. Other oddities are gallbladder fistulas emptying into the pleural and pericardial cavities. Vomiting of gallstones has occurred. Some two years ago at the Duval Medical Center, a white woman was admitted with what appeared to be a superficial abscess of the anterior abdominal wall. The abscess became fluctuant, was incised and spewed forth purulent fluid as well as many small multifaceted black gallstones.

Once a stone has entered the intestine, it usually is carried along with the intestinal contents and is finally expelled unless obstruction occurs. Tremendous variations take place in the speed at which the stones travel through the intestinal lumen. Cases have been reported in which stones passed from the gallbladder into the duodenum and thence in the stool out through the rectum in three hours. In one case a stone traversed the length of the small and large intestine in a period of one month. Wagner[14] reported 334 cases of intestinal obstruction from gallstones in which cure was effected in 93 by the stone having passed through the rectum. In 1936, Mast[16] reported recurrent intestinal obstruction from one stone, which moved through the small intestine for a period of several years. The probable time of perforation of this gallstone was ascertained by the history. Its passage through the small intestine resulted in repeated attacks of partial intestinal obstruction, only to be relieved by resumption of the stone's downward movement. Eventually, the stone lodged and was removed surgically from the ileum.

Diagnosis

Symptoms of gallstone ileus are often vague. If obstruction occurs after a typical biliary seizure, the diagnosis is suggested. In a number of the reported cases, however, there was no definite history of previous gallbladder disease. Foss and Summers,[17] in a study of 150 cases of gallstone ileus, reported that 15.3 per cent of the patients had denied any history implicating the gallbladder, 36.6 per cent had had pain somewhat suggestive of biliary colic, and only 32 per cent had experienced pain suggesting perforation of the gallbladder. Hinchey[18] believed that in the majority of cases of gallstone ileus, disease of the gallbladder is suggested by a history of chronic dyspepsia, belching, varying intermittent attacks of pain in the right upper quadrant of the abdomen, nausea, or vomiting. The usual history is

simply persistent vomiting with mild to moderate crampy abdominal pains in an elderly woman who has had no previous abdominal surgery.

The distinction between intestinal colic and intestinal obstruction is rather well illustrated in Hinchey's case of recurrent gallstone ileus. The patient suffered colic with both defecated stones, but had no nausea, vomiting, distention or obstipation. Then the colic recurred associated with vomiting, obstipation and roentgen evidence of obstruction. Surgical intervention at this time consisted of removal of an impacted stone from the small intestine. This sequence of symptoms cannot be relied upon. Once the stone gets into the intestine, usually there will be intermittent episodes of varying degrees of obstruction with intense, colicky pains, vomiting and obstipation. A number of authors commented on the lack of distention, indicating that some gas and feces must pass by the stone. Spasm of the intestine subsides at the site of obstruction, the stone moves distalward, and the obstruction may be temporarily relieved, only to have the stone produce new intraluminal irritation at a more distal site followed by renewed spasm and obstruction. The block is obturator in type, and consequently circulation is seldom impaired. Tenderness is therefore minimal unless necrosis from pressure develops, followed by localized peritonitis. Wangensteen[9] thought that the obstruction is in the nature of a volvulus, owing to the fact that when fluid and food accumulate above the point of obstruction, the increased weight of the segment may produce torsion of a loop.

Figiel, Figiel, Wieterson and Dranginis,[19] in a well illustrated paper, pointed out that gallstone obturation is a mechanical obstruction which can be diagnosed preoperatively by the radiologist with a considerable degree of accuracy. The roentgen findings of gallstone ileus are: (1) air or contrast medium in some part of the biliary tract showing the presence of a cholecystoenteric fistula, (2) direct visualization of the stone, or indirect visualization of the stone by contrast medium in the small intestine, (3) change in position of a previously observed stone, and (4) roentgen evidence of partial or complete intestinal obstruction.

Recurrent Gallstone Ileus

While gallstone ileus is comparatively infrequent, recurrent gallstone ileus appears to be exceedingly rare. After carefully reviewing the literature, I have been able to collect 16 cases in which the diagnosis subsequently was proved by a second laparotomy. In one additional case, not included in this series, the diagnosis of recurrent gallstone ileus was established at necropsy. This case was reported in 1922 by Pybus,[20] who saw a 65 year old, thin woman seven days after hospitalization for persistent vomiting. Enemas gave relief, but two days later nausea and vomiting returned. A small, hard mass could be palpated in the right iliac fossa. At laparotomy a faceted stone the size of a golfball was removed from the terminal portion of the ileum. The symptoms recurred four days later, and a diagnosis of leakage of the suture line was made. Peritonitis appeared to develop, and the patient died a few days later. On postmortem examination, a generalized peritonitis was present due to a perforated ileum, which was the result of an impacted stone 2 feet proximal to the enterostomy from which the first stone had been removed. Some distance above this site another stone was impacted with a similar perforation. There was a fistula between the gallbladder and the duodenum.

Several years later this author saw another 65 year old woman with a similar history of vomiting for four days associated with colicky abdominal pains. In this case there was a history of biliary colic for the previous 18 years. A diagnosis of gallstone ileus was made, and at operation a stone was removed from the lower portion of the ileum. Two smaller stones were removed from the gallbladder, and a cholecystoduodenal fistula was closed. After observing these two cases, Pybus[20] advocated that a search be made for additional stones in the distended portion of the small intestine, that the gallbladder be examined, and that stones found in the gallbladder be removed. Wakefield and his associates[15] reported a series of 10 cases of intestinal obstruction produced by gallstones, observed at the Mayo Clinic, in six of which stones also were found in the gallbladder or bile passages at operation or at necropsy.

Holz[14] in 1929 collected five cases of recurrent gallstone ileus. He likewise made the plea that if the gallbladder contained additional stones, they should be removed, provided removal would not endanger the patient's life. Noskin and Tannenbaum[21] in 1952 concluded that recurrent obstruction would not occur if cholecystectomy were performed after the initial attack of gallstone ileus.

Table 1. — Summary of Cases of Recurrent Gallstone Ileus in Which Surgery Was Repeated

Author	Age	Previous Cholecystic Disease	Signs and Symptoms of Intestinal Obstruction	Location of Stone at First Laparotomy	Size of Stone	Interval Before Return of Symptoms of Intestinal Obstruction	Location of Stone at Second Laparotomy	Size of Stone
Downes[22] 1911			Yes	Small intestine		2 days	At site of initial enterotomy	
Wagner[14] 1914	72	No	Yes	Midileum		12 days	10 cm. above site of first enterotomy	
Wagner[14] 1918	72		Yes	Small intestine		4 days	At site of initial enterotomy	Smaller than first
Wohlaer[14] 1924	69	Yes	Yes			1 year		Walnut-sized
Hille[14] 1925	61	Yes	Yes		Hen's egg	3 days	Middle of small intestine	
Hass[14] 1927	69		Yes	Ileum		3 months	At site of initial enterotomy	Larger than first
Goldammer[10] 1930			Yes	Small intestine		6 weeks	2 stones, 1 at site of first obstruction	
Schwarke[23] 1938	69	For 20 years	Present 3 days	Midjejunum	5.3 cm.	4.5 months	Upper ileum	3.5 cm
Hinchey[18] 1940	79	Vague symptoms	Present 2 days	Small intestine	3 x 3 x 3.1 cm.	3 months	Small intestine	3.2 x 3.2 x 2.9 cm.
Hand and Gilmore[3] 1943	63	For 20 years	Sudden onset of right upper quadrant pain with signs of intestinal obstruction	Midjejunum	2.5 cm.	8 days	Midjejunum	2.5 cm.
Lee, M.[7] 1945	87		Present 3 days	Lower ileum	Walnut	3 months	3.5 ft. from ileocecal valve	Golf ball
Vin Zant and Hibbard[24] 1949	85	Confirmed by x-ray	Present 4 days with pain in left upper quadrant	Lower jejunum	3.5 cm.	2 months; x-rays showed stone moved to right upper quadrant	Terminal ileum	3.6 cm.
McGreevy and McGreevy[25] 1950	63		Apparently due to uncorrected umbilical hernia	Ileum	3.5 cm.	14 days	Lower jejunum	One-half size of first stone 1.75 cm.
Noskin and Tannenbaum[21] 1952	69		Present 6 days	30 cm. from ileocecal valve	Lime	13 months	At site of initial enterotomy	Golf ball
Milch, Mendez and Murphy[4] 1952	57		Present plus x-ray evidence of gas in biliary radicals and stone in right upper quadrant	24 inches from ileocecal valve	4.3 cm.	3 months	60 cm. proximal to site where first stone was removed	2.5 x 4 cm.

Macfarlane[26] 1953	57	Yes	Present 2.5 days	2 ft. proximal to ileocecal valve	2.5 cm. single facet	10 days	Twentieth post-operative day stone at site of initial enterotomy	3.8 cm.
Collins 1956	82	No	Present 4 days	Lower jejunum	2.5 x 2.5 x 3.5 cm.	5 days	75 cm. proximal to ileocecal valve	2 x 2 x 2.5 cm.

The 16 collected cases and the case here reported, in which laparotomy was performed a second time for recurrent gallstone ileus, are summarized in table 1. All of the patients were women, ranging in age from 57 to 87. The interval between laparotomies ranged from two days to one year. There were two fatalities with a mortality of 11.7 per cent. In one of Wagner's cases,[14] death resulted from coronary disease a few hours after surgery, and in Wohlaer's case,[14] from pneumonia on the seventh postoperative day. A history of gallbladder disease was definitely elicited in six of the 17 cases. Two patients had no previous symptoms of gallbladder disease upon careful interrogation. The size of the stones varied from 1.75 cm. to that of a hen's egg. The various sites of obstruction were located all the way from the pylorus down to the lower portion of the ileum. In the case of Hand and Gilmore[3] the intestine was collapsed distal to the site of the obstructing stone and so was palpated for a distance of only 2 feet beyond this area. At the second laparotomy the stone was found slightly more than 2 feet distal to the first enterotomy, and its size would have prevented it from passing through the constricted lumen at the site of the first enterotomy. In only five of the cases was a preoperative diagnosis of gallstone ileus made at the first operation. The diagnosis of recurrent gallstone ileus was made in only four cases, including the case reported here. In three of the cases[4,10,25] and in the present case, an additional stone was known to be present in the gallbladder at the initial surgical exploration, but the patient's precarious condition prevented surgical removal. The patient of Milch and his associates[4] later refused elective removal of the stone; three months thereafter this stone produced a recurrent intestinal obstruction.

In all of these cases signs and symptoms of intestinal obstruction were present in varying degree. Hille[11] and Hand and Gilmore[3] reported that these symptoms came on suddenly along with pain in the right upper quadrant of the abdomen, whereas in the remaining cases the patients volunteered a history of vomiting associated with abdominal pain for two to 10 days before consulting their physician. In one case[18] the patient vomited for two days and then passed a two-faceted stone. Four days later she passed another hard object, but signs of obstruction then became more pronounced and surgical intervention was required.

In the case presented, the patient was the oldest one of the series in whom recurrent gallstone ileus occurred in the immediate postoperative period. The first stone (fig. 4), which was the larger of the two, had three facets, the largest facet matching a single facet on the second stone. The two smaller facets were apparently formed by smaller stones which undoubtedly passed through the gastrointestinal tract without producing symptoms, prior to the first obturative obstruction.

Of the 17 cases, in only one was the patient advised to have an additional surgical procedure for the purpose of closing the cholecystoduodenal fistula. In the reports of the remaining cases concern was not expressed that any disability might arise from this defect. This view has been well borne out by an 18 month follow-up of the case presented.

Report of Case

Mrs. M. M., an 82 year old white woman, was admitted to the Duval Medical Center on Dec. 25, 1954, as a patient of Dr. William G. Harris. She complained of persistent vomiting and obstipation of four days' duration. The vomitus had the consistency of green pea soup. The patient stated that she had experienced severe sharp pains in the right upper quadrant of the abdomen for several days prior to the onset of vomiting, which had gradually disappeared. She then began vomiting without abdominal pain. For two days prior to admission she had passed neither flatus nor feces. She denied any food intolerance, indigestion, melena, constipation, or loss in weight. She had had no previous surgery or serious illness.

On physical examination, the pulse was regular with the rate varying from 110 to 120, the temperature was 98 F., and the blood pressure was 140 systolic and 80 diastolic. The abdomen was only slightly above plane and soft. There was dulness to percussion in both flanks. A fluid wave was present. Pelvic examination revealed only slight tenderness high in the posterior fornix. Firm brown feces were present in the rectum. A roentgenogram (fig. 1), taken on admission, revealed a large gallstone in the gallbladder area, and there were several gas-filled loops of small intestine in the midabdomen with a relative absence of gas in the colon. A nasogastric tube

Fig. 1. — Roentgenogram of Dec. 25, 1954. Calcific-rimmed large stone in the gallbladder (arrow). Stone which has passed into the intestine is not seen. No gas is seen in the bile ducts which would establish the diagnosis at this time. Moderately gas-distended small intestine in midabdomen, which suggested small intestine obstruction at this time.

was inserted for continuous Wangensteen suction, and the patient was given intravenous fluids. Urinalysis revealed a specific gravity of 1.004, 2 plus albumin, and 60 to 80 red blood cells per high power field. The hemoglobin was 14 Gm., and the white blood cells numbered 18,000 with 87 segmented forms. The nonprotein nitrogen was 110. The following day the nonprotein nitrogen had dropped to 96.

At operation, a moderate amount of serous fluid was present, and the entire jejunum was distended. At about the distal end of the jejunum there was a large, stony-hard mass within the lumen of the intestine, measuring some 2.5 by 2.5 by 3.5 cm. in size. Distal to this mass the intestine was collapsed. A rapid examination of the remainder of the small intestine revealed no further intraluminal masses. The gallbladder was adhered to the surrounding structures. There could be felt, apparently inside the gallbladder, a stone about the size of the one seen in the roentgenogram. No apparent communication between the small intestine and the gallbladder could be palpated. It was decided that nothing should be done to the gallbladder at that time because of the precarious condition of the patient. A linear incision was then made along the free border of the jejunum, and the stone was removed; it contained three facets.

The next day the patient passed gas and complained only of being unable to sleep at night. The abdomen was moderately distended, and peristalsis was present. On the second postoperative day the administration of oral fluids was begun. The patient complained of nausea. She continued to appear dehydrated, but began taking a soft diet the third postoperative day and got out of bed daily. On December 31, she complained of nausea, which had not been present the day before, and on Jan. 1, 1955, she began to vomit. Peristalsis was hyperactive. A flat film (fig. 2) of the abdomen showed the stone, previously seen in the right upper quadrant, now appearing in the right lower quadrant. Dilated loops of small intestine were visible, and gas appeared to be present in the bile ducts. A diagnosis of recurrent gallstone ileus was made, and at operation a 2 by 2 by 2.5 cm. stone (fig. 3) approximately 75 cm. from the ileocecal valve was removed.

Following this laparotomy the course was mildly septic with the temperature spiking to 100.1 F. on the twelfth postoperative day. The patient received various antibiotics and slowly recovered. The abdomen remained somewhat distended. A small polyethylene feeding tube was inserted through the nose into the stomach, as it became difficult to get the patient to take liquids or solids. Enemas were frequently necessary. A roentgenogram of the chest on January 19 showed an ill-defined opacity in the lower lobe of the right lung which was probably an early pneumonia. On February 2 roentgen examination of the gastrointestinal tract (fig. 4) revealed a normal duodenal bulb and stomach with a definite exit of barium into a small tract extending superiorly and laterally from the second portion of the duodenum. This evidence accentuated the previous supposition that the gallstones passed through a cholecystoduodenal fistula into the small intestine.

The patient gradually improved and was discharged in good condition approximately five weeks following the second laparotomy. She was seen at her home in July and again in December 1955, and appeared to be in good health with no gastrointestinal symptoms.

Summary and Conclusions

A case of recurrent gallstone ileus in which the patient was operated on the second time is reported, and 16 such cases collected from the literature are reviewed. The case reported is the

Fig. 2. — Roentgenogram of Jan. 1, 1955. The stone previously seen in the gallbladder is now seen in the ileocecal region (black arrow). There is gas in the biliary tract (white arrow). There are loops of gas-distended small intestine in the lower portion of the abdomen, suggestive of low small intestine obstruction.

Fig. 3. — Roentgenogram of Feb. 2, 1955. Demonstrates the fistulous tract (arrow) communicating with the second portion of the duodenum.

fifth in this series in which the patient was subjected to a second operation in the immediate postoperative period following the first operation, and the patient was the oldest of this group.

The incidence, mortality, pathologic process and diagnosis of gallstone ileus are discussed.

A diagnosis of gallstone ileus can be made preoperatively by roentgen evidence of cholecystoenteric fistula with the presence of air or contrast medium in the biliary tree, direct visualization of the obstructing stones or distention of the small intestine. The most significant clinical finding is persistent vomiting with mild to moderate abdominal pains, although pain may be entirely absent.

Therapy for gallstone ileus belongs in the domain of the surgeon, and surgical intervention should be seriously considered before the patient's condition deteriorates if the diagnosis of obstruction from gallstones cannot be ruled out.

If a stone is found producing obstruction and has facets, there probably have been or still remain other stones in the intestinal tract or in the gallbladder.

The entire small intestine should be examined from the ligament of Treitz down to the ileocecal valve in order to locate and remove additional stones.

The gallbladder should be palpated, and any remaining stones should be removed, or milked through the fistula and down the small intestine for removal or a cholecystectomy should be performed, depending upon the patient's condition. Although this latter procedure was first suggested by Pybus[20] in 1922 and repeated by Holz[14] in 1929, it was not mentioned in nine cases of this series which have since been reported. Undoubtedly the results would make its importance more fully appreciated if recurrent gallstone ileus occurred more frequently. Probably in most of these cases attempts to remove the gallbladder or its contents were deemed unwise because of the patient's poor general condition as well as the inaccessibility of the gallbladder from the incision made to explore the abdomen. These two reasons were factors in the case presented. The wishful thinking that cholecystectomy might be postponed to the period of postoperative convalescence is a dangerous thought for in five of the 17 cases of this series recurrent gallstone ileus occurred within the first eight days after the initial operation, necessitating a second laparotomy.

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Fig. 4. — Stones producing obstruction. The larger stone caused the initial obstruction.

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ABSTRACTS

The University in Medicine. *Concept of the New Program at the University of Florida.* By George T. Harrell Jr., M.D. J.A.M.A. 161: 700-704 (June 23) 1956.

The Dean of the College of Medicine of the University of Florida here describes the student-centered program being developed at the university which emphasizes the training of the family physician for practice in the local community as a student may expect to find it 10 to 20 years hence. A university-wide theme of human biology is being used, so that all resources of the university may be brought to bear to explore better methods of education of any person who may be used in a program of patient care in the local community, as well as better methods of patient care. The university must educate the student to be a citizen, and the professors within the medical school must have a sufficiently broad background to contribute to this aspect of his development. He must also be prepared to accept responsibility for definitive medical care of the families in his charge and to ease not only the medical but also the sociologic, psychologic, and economic impact of disease upon the family. Once this basic philosophy was formulated, the physical plant was designed, the selection of the faculty begun, and the development of a curriculum undertaken to implement it.

This approach of exploring the role of the university in medicine rather than the more traditional one of merely charting the role of the medical school in a university is unique, as are the facilities being provided. Commenting on the objectives of this timely pioneer project, Dr. Harrell explained: "We are attempting to impress on the student that the basic principles in medicine are simple and that the adaptation to the particular disease problem at hand must be done with his own knowledge and ingenuity. We hope that these facilities will emphasize to the student that we are dealing with a variable biological system. No two individuals are the same, and no single individual when studied successively in point of time reacts in exactly the same way. . . . The practice of medicine will forever remain an art and can never be a science. For this reason both the preprofessional and the professional training should emphasize more of the art of understanding and handling people."

The Surgical Treatment of Mitral Stenosis. By W. C. Sealy, M.D., John P. Collins, M.D., and Richard G. Connar, M.D. North Carolina M.J. 15:202-205 (May) 1954.

Experiences with the surgical treatment of mitral stenosis are presented in this article. A series of 34 cases is analyzed in which the patients

were 13 men and 21 women, all considered to be good candidates for surgery. Their ages varied from 22 to 56 years. In one case a valve orifice of sufficient size for adequate function was demonstrated at operation, although careful preoperative studies including cardiac catheterization indicated the presence of a tight mitral stenosis. One death occurred on the third postoperative day from a massive auricular thrombus which had occluded the mitral orifice. The results were classified as excellent in 41 per cent of the cases and good in 40 per cent; in 12 per cent there was improvement with freedom of distressing symptoms although physical activity is still curtailed.

The authors observe that the surgical correction of mitral stenosis is a rational procedure and is now indicated whenever it is the cause of disabling symptoms. They conclude that no patient with a symptomatic tight mitral stenosis should be denied the benefit of this procedure.

Dissecting Aneurysm of the Aorta. By Elwyn Evans, M.D., and Robert W. Curry, M.D. South. M. J. 49:238-243 (March) 1956.

A general discussion of dissecting aneurysm of the aorta is presented. Although the diagnosis is made much more often than it was a decade or so ago, frequently the condition still remains undiagnosed. This condition, representing a small but important clinical and pathologic group, was present at autopsy in eight of 2,140 cases at the Massachusetts General Hospital.

A case of probable dissecting aneurysm of the aorta with re-entry and healing is presented. Symptoms that could hardly be explained in any other way were: interscapular pain radiating to the substernal region, occurring in a woman 63 years of age with atherosclerosis and hypertension while straining at stool, subsequent epigastric pain and pain in the left shoulder and left scapular region, fever, leukocytosis, and definite roentgenographic evidence of increase in width of the thoracic aorta in serial films, and a later decrease in width of the aorta.

Other corroborative signs and symptoms of unusual interest were hemoptysis associated with an aortic diastolic murmur and myocardial failure, a combination indicative of the dissection extending to or near the aortic ring. Although systolic murmurs along the dorsal spine have been noted in patients with dissecting aneurysm of the aorta, the authors knew of no other case in which a striking decrease in the intensity of such a murmur has been reported. A grade III systolic murmur between the sixth and eighth dorsal vertebrae heard earlier was barely audible four weeks later. In their opinion the production of a localized aortic constriction by an intramural thrombus and subsequent re-entry of the dissection into the aortic lumen best explains the striking changes of the murmur in their case.

Behavior of Split-Thickness, Dermal and Full-Thickness Skin Grafts in Thoracic Cavity, An Experimental Study. By Charles E. Horton, M.D., Frank Campbell, M.D., Richard Connar, M.D., Joseph McWhirt, M.D., and Kenneth Pickrell, M.D. A. M. A. Arch. Surg. 70:221-228 (Feb.) 1955.

In this experimental study in order to determine normal growth characteristics of skin in the thorax, a total of 51 intrathoracic grafts varying in size from 2 to 4 sq. cm. were observed for periods of from one to six months. This experiment readily established the relative value of autogenous split thickness, dermal, and full thickness skin growth in the thoracic cavity. Since split thickness skin grafts formed unilocular cysts on intact pleural surfaces whereas dermal and full thickness grafts did not, a definite superiority of the latter types of buried grafts was demonstrated. It was also apparent that the dermal graft has all of the virtues of the full thickness graft, and in addition, possesses certain extra qualities of desirability. The dermal graft did not temporarily grow hair as did the full thickness graft. Potentially, the dermal graft was a cleaner graft, with less likelihood of infection from skin bacteria.

The authors presented and discussed their various findings and then discussed the possible clinical applications of these findings. They concluded that dermal grafts are apparently superior to full thickness and split thickness grafts in the majority of intrathoracic grafting procedures. In view of the many potential uses for free living grafts in the chest, they expressed the belief that the investigation of such buried grafts should be continued.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

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An Evaluation of Oral Antidiabetic Drugs

The impact of a new therapeutic measure is sometimes greater on the physician than is the response of the patient to the drug. The recent advent of the oral antidiabetic compounds in the field of therapeutics has served a purpose far beyond their pharmacologic actions.

Firstly, these compounds once again remind us that the cause of diabetes is as yet unknown. They certainly should dispel the last lingering belief that diabetes mellitus is merely a disease of insulin lack. Despite the brilliant work of Houssay, Long and others years ago, some able clinicians still believe that since insulin is formed in the pancreas and diabetes mellitus can be controlled by insulin, ergo, diabetes is solely a deficiency disease of insulin.

It has been thought by many observers that diabetes mellitus is a clinical syndrome with more than one etiologic agent and having as many as four clinical types. Lawrence's classification of diabetes mellitus, although certainly not proved, offers an excellent point of departure from the orthodox belief that all hyperglycemia with glycosuria stems from the same source and causes similar physiopathologic changes in the patient.

Secondly, probably because of premature publicity and the inane desire for most Americans, especially physicians, to be first, the oral antidiabetic compounds were released to certain physicians supposedly well versed in diabetes for clinical trial. Unfortunately, these drugs have failed to measure up to the delirious press reports first given them. Briefly, they do not have any effect on many diabetic patients, and toxic reactions have occurred in over 5 per cent of patients. Unfortunately, some reactions were severe, including myocarditis, agranulocytosis and hepatitis with some resulting fatalities.

There are in America today many excellent medical schools with associated hospitals whose patients may be used for teaching purposes. By the very nature of these institutions adequate clinicians, research workers, instructors, laboratory personnel and other ancillary aids are at hand to make for a leisurely and thorough appraisal of a patient's ills, together with his therapeutic response to any medicine. Here are inculcated into the medical students the precepts of medical sciences and arts as far removed from the exigencies of private practice as is possible —

sometimes too far. But here is where new drugs should be tried. It is wrong for pharmaceutic firms to allow physicians in private practice to use drugs still in the experimental phase. Wrong because the physician — specialist or generalist — cannot, with rare exceptions, devote the time, effort or expense which the true evaluation of a new drug entails. He likewise cannot evaluate its true efficacy since he has an inherent desire to be first with anything new. Furthermore, it is rare even for a specialist in one of the "subspecialties" to have enough patients of one type at any one time for therapeutic evaluation — unless he suspends the major portion of his practice during any test period.

Thus the appearance of oral antidiabetic compounds served a worthwhile purpose even if they are soon consigned to oblivion. They have once again awakened physicians to the fact that diabetes mellitus is not the simple deficiency disease it was thought to have been soon after the discovery of insulin. These compounds will undoubtedly lead to further studies for other antidiabetic drugs — a search which was practically stopped with the discovery of insulin. Finally, these antidiabetic drugs, toxic as they are, should serve as a warning to all drug manufacturers and physicians alike. No experimental drug should come into the hands of the average practicing physician who has neither the time, facilities, resources nor personality for its true evaluation. If the oral antidiabetic drugs have accomplished this end, they will have become a greater medical milestone than even their most enthusiastic supporters at first imagined.

Hospital and Medical Facilities Construction in Florida

Hill-Burton Program. — Florida has been a major beneficiary of federal legislation to promote adequate hospital facilities for the nation. There was little hospital construction in Florida, other than for the military services, during World War II and for several years thereafter. As a result, the state was confronted with a critical shortage of hospital beds. Fortunately, the federal government in 1946 recognized the need for hospitals throughout the nation, and the Congress realized that it would be impossible for the local communities to assume the full financial burden in meeting this need for medical facilities. Accordingly, through the combined efforts of medical associations, hospital associations, and other organizations interested in the health fields, Public Law 725, popularly referred to as the Hill-Burton Act and also known as the Hospital and Medical Facilities Survey and Construction Program, was enacted. Florida had the distinction of having the first hospital in the United States to be constructed under this program — the Suwannee County Hospital at Live Oak.

In 1947, the state received its first allotment of funds in the amount of $1,460,260. Since that time federal funds have participated in hospital, public health, and other medical facilities construction projects costing over $57,900,000, of which $19,900,000, or 34.37 per cent, was in direct federal grants. Of the general hospitals built under this program, the large majority are located in areas which had no hospital. When the current building schedules are completed, only 11 of Florida's 67 counties and three hospital areas will be without any hospital facilities as compared with 24 counties and six hospital areas in 1947.[1]

The Florida State Improvement Commission, now the Florida Development Commission, with the advice of the Florida State Hospital Advisory Council administers a variable grant program which determines the percentage of cost to which the various counties in Florida are entitled. The amount of local matching funds required is dependent upon the factors used in the Florida School Program, which, in effect, is the per capita wealth or the ability to pay theory.

The priorities on funds for the different areas are based on the percentage of bed need met within the various counties in the state. The percentages for general hospitals range from 0 to 29.99 for A priority to 100 for E priority. Counties of 10,000 population or more with no hospital beds were given A priority. Counties with less than 10,000 population were grouped with other counties to make a logical hospital area capable of supporting a hospital of at least 25 beds. "Only once in the history of the Hill-Burton pro-

Suwannee County Hospital, Live Oak

Gadsden County Hospital, Quincy

Seminole Memorial Hospital, Sanford

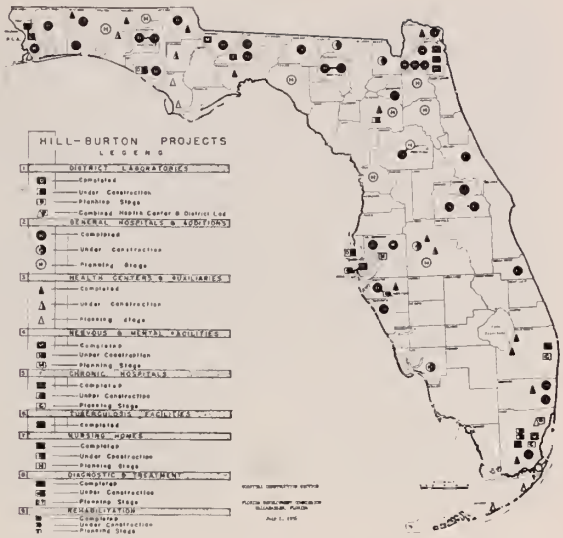
gram," said Dr. Walter C. Payne Sr. of Pensacola, chairman of the Hospital Advisory Council since it was established in 1946, "has it been possible to render aid to the facilities in a county holding a priority below B. During the last year there were active applications on file requesting over $10,000,000 in federal aid for projects involving approximately $25,000,000 in total construction and equipment costs. This demand convinces the Florida State Hospital Advisory Council that a great need for hospital beds of all types still exists in Florida."

The number of beds needed in a given area is determined by federal formula. The Hill-Burton Act established these criteria to determine where the need is greatest: 2.5 beds per thousand for areas having a population of less than 25,000; 4 beds per thousand for areas with a population between 25,000 and 100,000; and 4.5 beds per thousand in the metropolitan areas having more than 100,000 population. The ratios of bed needs to population, shown in the following table,[1] are based on these federal formulas. This table

Memorial Hospital, Hollywood

presents a general picture of Florida's bed gains in relation to need for the 1947-1956 period and takes into account all acceptable beds existing, under construction and in current construction schedules as of July 1, 1956. The population gain for this period was 49.56 per cent.

Year	Bed Type	Total Beds Needed	Existing Accept. Beds	Percent Need Met	8-Year Gain Percent
1947	General	10,119	6,599	65.2	
1955	General	15,142	11,643	76.90	11.70
1947	Chronic	4,497	485	10.7	
1955	Chronic	6,728	768	11.76	1.06
1947	Mental	11,243	5,842	51.9	
1955	Mental	16,820	9,328	55.46	3.56
1947	Tuberculosis	2,180	515	23.6	
1955	Tuberculosis	1,121	1,954	100.00	76.4



General Hospitals. — According to the 1955-1956 inventory, Florida has 11,643 acceptable general hospital beds, a net gain of 1,065 over the 1954-1955 inventory. There are 1,380 general hospital beds either under construction or in the current construction schedule; of these, 615 are being constructed with federal assistance. The current inventory does not include a 400 to 500 bed teaching hospital, now in the early stage of construction, at the new College of Medicine of the University of Florida at Gainesville. A psychiatric unit is planned, but the bed breakdown and other data were not available. They will be included in next year's survey of the Florida State Plan. The accompanying map shows the distribution of the state's general hospitals, in the completed stage, under construction and in the planning stage, participating in the Hill-Burton Program as of July 1, 1956.[1]

Of the 11,643 acceptable general hospital beds now existing, 5,044 have been built since 1947. Certainly these beds represent a great advance in quality over those of 1947. With 76.90 per cent of the need now met, the eight year gain is nevertheless only 11.70 per cent. This small gain is explained largely by the astronomic growth in population that Florida is experiencing annually.

Several of the hospitals classified as acceptable are fast approaching maximum patient loads. They are obsolete for the demands incurred by scientific and technologic advances, and are not amenable to conversion. Such facilities, under the continuous program of reappraisal, are gradually being reclassified. In addition to general beds in acceptable structures, there are now in use 937 beds in structurally unacceptable facilities.

It is noteworthy that in many instances the relatively low annual "average" occupancy rates

The Fish Memorial Hospital, DeLand

Madison County Memorial Hospital, Madison

reported for a number of hospitals do not reflect bed use and bed need properly because of low census periods during two to four months of the year. A number of hospitals, especially small ones, in some areaas where the general hospital census appears to indicate an adequate margin of beds available for emergency and similar use, are rapidly approaching maximum occupancy rates for safe, good quality patient care. This situation applies also in some areas showing, by application of federal formula, a large per cent of bed needs met. Florida is confronted not only with a steady and rapid growth in permanent population but also with a swelling tourist population over an increasingly extended tourist season. During four months of the year, the population of certain cities and counties doubles, and many sections observe little difference between the number of winter and summer visitors. The growing volume of migratory and defense installation workers poses an additional problem. All of these factors, if weighted in the federal bed formula, undoubtedly would reveal Florida's general hospital bed supply to be considerably less adequate than shown. Certainly these considerations make any formula which is applicable to the nation as a whole definitely inadequate for Florida. In 1955, Florida had nearly 27,000 more admissions to general hospitals and provided approximately 244,000 more days of patient care than in 1954.[1]

St. Luke's Hospital, Jacksonville

West Orange Memorial Hospital, Winter Garden

Other Facilities. — Other Hill-Burton projects in the state include facilities for the chronically ill, mental institutions, tuberculosis hospitals and public health facilities. Their distribution and stage of development are indicated on the map, and the table presents the current picture statistically.

The greatest deficiency in Florida's bed needs is for the chronically ill, the net gain since 1947 being only 1.06 per cent. Florida has less than 33 per cent of her nursing home bed needs. Many of the boarding, custodial, and nursing homes which provide some 7,000 beds are structurally unsafe and offer minimal care. They care primarily for the aged who are ill, a group heavily weighted in the upper age bracket.

In the field of mental health, the quality of facility structure and care standards in existing hospitals, as with general hospitals, has improved greatly since 1947, but the quantitative gain of 3.56 per cent is small. The state now has 55.46 per cent of beds needed for mental patients, little more than half of the number considered adequate.

The greatest progress has been made in the supply of acceptable tuberculosis beds. There are now 1,954, as compared with 515 in 1947, a number which is adequate for total current needs. Over 59 per cent of the 1,439 new beds built since 1947 were built with federal assistance. The construction of new beds and the great reduction in the number of tuberculosis beds needed per thousand population are responsible for the progress in this category. Since 1945 the tuberculosis death rate has declined in Florida

Santa Rosa Hospital, Milton

North Broward General Hospital, Fort Lauderdale

South Florida Baptist Hospital, Plant City

Munroe Memorial Hospital, Ocala

Indian River Memorial Hospital, Vero Beaach

from 31.1 to 7.9 in 1955 despite a population increase of almost 50 per cent.

The need for public health facilities remains great. Florida now has about 44 per cent of the number of health centers necessary and only about 12 per cent of needed auxiliary health centers. Sixteen public health projects have been built or are being built with the aid of federal grants. On the basis of current population, however, 22 health centers, 143 auxiliary health centers, and two district laboratories are still needed. Some areas are in critical need of facilities for carrying on the most basic health functions.

From this brief survey it is obvious that the contribution made to the health and welfare of the people of Florida by the Hill-Burton Program of federal aid has been and will continue to be of inestimable value. Qualitatively, it is particularly significant. Quantitatively, it has aided greatly in enabling hospital and medical facilities construction to keep pace with the phenomenal population growth and even to gain a small margin. In addition, it has been instrumental in attracting physicians to rural or isolated areas receiving inadequate medical attention. "During the last seven years," said Dr. Payne, "we have seen many rural areas construct 25 bed hospitals. These smaller hospitals have in all cases attracted at least one new physician to the community." As examples, he cited Madison County, Hamilton County, Bradford County and Okalcosa County hospitals, one physician each; Suwannee County and Santa Rosa County hospitals, two physicians each; and Washington County Hospital, three physicians.

Since its inception, the manner in which the Hospital and Medical Facilities Survey and Construction Program is administered in Florida has remained unchanged. There have been no exceptions to the priority system, and the variable grant is based on the same factors as used in the original plan with the index of tax-paying ability of the various counties computed by the State Department of Education and approved by the Florida legislature. The accompanying photographs of hospitals built or remodeled in recent years with Hill-Burton aid illustrate how generously Florida has benefited under this program.

Baptist Memorial Hospital, Jacksonville (without Hill-Burton aid)

St. Luke's Hospital in Jacksonville, established in 1873, bears the distinction of being Florida's first hospital. It affords an excellent example of a continuing modernization program by a private hospital over a long period. Hill-Burton funds have made up approximately 15 per cent of the extensive remodeling and expansion expenditures in recent years.

Progess Without Hill-Burton Aid.—Hospitals in the state depending entirely upon private funds for construction and improvements have made an important contribution to Florida's bed need which has materially brightened the hospital picture. Among these are five hospitals listed by the Florida Development Commission as having a total bed capacity of approximately 750.[2]

The largest of these is the Baptist Memorial Hospital in Jacksonville with 310 beds, costing approximately $5,000,000, which opened in the fall of 1955. Another large hospital in this category is the Holy Cross Hospital in Fort Lauderdale, and other such hospitals in smaller communities are Naples Memorial Hospital in Naples, Winter Park Memorial Hospital in Winter Park, and The Fish Memorial Hospital in New Smyrna Beach.

While much progress has been made in recent years by tax-supported and privately owned hospitals, with federal aid and without such assistance, the margin of gain is exceedingly small because of Florida's enormous growth in population and other problems peculiar to the state. An urgent need for hospital beds of nearly all types continues to exist. Renewed efforts will widen the margin of gain each year if all groups will endeavor to press forward with enthusiasm toward the ultimate goal of adequate hospital and medical facilities for all in this great state.

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1 Florida State Plan for 1956 Administered by the Hospital Section-Florida Development Commission, Tallahassee. Published in November 1956.

2. Letter from Miss Ann Bland, Hospital Consultant, Hospital Construction Division, Florida Development Commission, Tallahassee, dated Dec. 15, 1955, with a tabulation of hospital construction, completed and/or underway, without federal aid at that time.

Report of Delegates to American Medical Association 1956 Clinical Meeting

Medical ethics, veterans' medical care, radioactive isotopes, continuance of the A.M.A. interim session, hospitalization for patients with alcoholism and a report of the Committee on Medical Practices were among the wide variety of subjects acted upon by the House of Delegates at the American Medical Association's Tenth Clinical Meeting held Nov. 27-30, 1956, in Seattle.

Dr. Edward M. Gans of Harlowton, Mont., was announced at the opening session on Tuesday as the 1956 General Practitioner of the Year. The annual award, carrying with it a gold medal and a citation, is presented to a family doctor selected by a special committee of the Board of Trustees for outstanding community service. Dr. Gans, who is 80 years old, has practiced medicine for 51 years and has been in the Harlowton area for the past 44 years.

Strongly condemning government intervention in medicine, Dr. Dwight H. Murray of Napa, Calif., A.M.A. President, told the opening session that "the medical profession, along with business and industry, is caught between those who desire to promote sound government programs and those who desire even more intensely to perpetuate party politics. Unfortunately, in recent years a benevolent federal government appears more attractive to the voting public than the preservation of individual freedoms. Medicine must do its utmost to reverse this trend."

Total registration at the end of the third day of the meeting, with half a day still to go, had reached 5,191, including 2,738 practicing physicians and 2,453 residents, interns, medical students, nurses and guests.

Medical Ethics

Subject of greatest interest at Seattle was the proposed, 10-section revision of the Principles of Medical Ethics originally submitted at the June 1956 Annual Meeting in Chicago, where final action was deferred until the Seattle session. The proposed short version of the Principles was resubmitted at this session, with some changes based on suggestions received since last June by the Council on Constitution and By-Laws. The House of Delegates, however, decided to refer the matter back to the Council on Constitution and

By-Laws for further study and consideration. The reference committee report adopted by the House included the following statements:

"Careful consideration was given to the Preamble and the ten sections of the proposed Principles. The Preamble and seven of the ten sections appear to be acceptable in their present form.

"Sections 6 and 7 were not acceptable as presented either to the group which appeared at the hearing or to your reference committee.

"Out of the general discussion the reference committee received the crystallized opinion that at least four areas needed more specific attention in Sections 6 and 7. These are:

"(1) Division of fees;

"(2) The dispensing of drugs and appliances;

"(3) The corporate practice of medicine;

"(4) Greater emphasis concerning the relationship between physicians and patients.

"In addition, the reference committee felt that the wording in Section 10 could be improved if amended to read as follows:

> " 'The responsibilities of the physician extend not only to the individual but also to society and deserve his interest and participation in activities which have as their objective the improvement of the health and welfare of the individual and the community.'

"In view of the above your reference committee believes that the proposed Principles of Medical Ethics should be referred back to the Council on Constitution and By-Laws for further study and consideration of the above stated principles.

"In the short space of time at our disposal and in view of the importance of the subject, your reference committee did not deem it wise to attempt to properly phrase these concepts.

"We would also recommend that if possible this study be completed at least six weeks prior to the June session and that the new version be published in THE JOURNAL in order that all interested physicians might have an opportunity to comment thereon."

Veterans' Medical Care

The House revised A.M.A. policy on veterans' medical care by endorsing in principle the following paragraph suggested by the Council on Medical Service:

"With respect to the provision of medical care and hospitalization benefits for veterans in Veterans Administration and other federal hospitals that new legislation be enacted limiting such care to veterans with peacetime or wartime service whose disabilities or diseases are service-incurred or aggravated."

This action eliminates the temporary exceptions which were made in the June 1953 policy regarding wartime veterans who are unable to defray the expenses of necessary hospitalization for non-service-connected cases of tuberculosis or psychiatric or neurologic disorders. In making the policy change, the House approved this supplementary statement:

"We recognize the laws and administrative extensions of the law that are now in operation. We feel that under the circumstances it will be to the best interests of the public in general, and veterans in particular, if medical societies, county and state as well as national, develop committees to assist in guaranteeing VA hospital admission to service-connected cases. While the present law exists, we should help assure that veterans whose illness constitutes economic disaster will not be displaced by those suffering short-term remediable ills which, at the worst, constitute financial inconvenience."

In another action concerning veterans, the House passed two resolutions condemning as unlawful the practice of Veterans Administration hospitals which admit patients who are covered by workman's compensation insurance or by private health insurance and which render bills for the cost of their care. Both resolutions requested the A.M.A. to take action to bring about a discontinuance of such practices by VA hospitals, and one of them instructed the Association Secretary to obtain from each state testimony or records of each known case that violates VA Reg. 6047-D1.

Radioactive Isotopes

The House rescinded the June 1951 action, which limited the hospital use of radium and radioactive isotopes to board-certified radiologists, by approving a new policy statement which says:

"(1) In any hospital in which a patient is to receive radium or the products of radium or artificially produced isotopes, there should be a duly appointed Committee on Radium and Artificially Produced Radioisotopes of the hospital professional staff. This committee should include, but not necessarily be limited to, the following qualified physicians: a radiologist, a surgeon, an internist, a gynecologist, a urologist and a pathologist. This committee should have available such competent consultation of other physicians

and scientific personnel as may be required by it. Where this is not practicable, the hospital staff should consult the nearest Committee on Radium and Artificially Produced Radioisotopes.

"(2) In any hospital, the use of radium or its products and artificially produced radioactive isotopes for diagnostic or therapeutic purposes shall be restricted to qualified physicians so judged by the Committee on Radium and Artificially Produced Radioisotopes of the professional staff to be adequately trained and competent in their particular use.

"(3) It is recommended that procurement, storage, dosimetry control and inventory of all radioactive isotopes for the use of the hospital staff and radiological safety control be centralized, and, where administratively possible, centralization be located in the Department of Radiology.

"(4) It is recommended that the Board of Trustees assign to the appropriate council or committee the continuous study of the problems of radiological safety control in the use of radium and its products and artificially produced radioactive isotopes for diagnostic or therapeutic purposes."

Clinical Meetings

Rejecting a resolution which recommended discontinuance of the interim sessions, or clinical meetings, the House adopted a reference committee report which said:

"We believe that the interim sessions should be continued because of the public relations value of these meetings to the Association and the educational value to physicians and the general public in the various geographical areas involved.

"It is the suggestion of the reference committee that maximum attention be given to these potential benefits in selecting a city for the interim meeting.

"It is our further recommendation that the Board of Trustees consider the advisability of holding an Interim Meeting of the House of Delegates in Chicago each November or December and an Interim Scientific Session in November or December of each year in different parts of the United States. The reference committee suggests that the views of the Board of Trustees in this regard be reported to the House of Delegates next June."

Hospitalization for Alcoholics

To implement educational approaches to the problem of alcoholism, the House approved a statement submitted through the Board of Trustees by the Council on Mental Health and its Committee on Alcoholism. The House also recommended that the statement be brought to the attention of the Council on Medical Education and Hospitals, the Joint Commission on Accreditation of Hospitals and the American Hospital Association. It includes the following:

"The Council on Mental Health urges hospital administrators and the staffs of hospitals to look upon alcoholism as a medical problem and to admit patients who are alcoholics to their hospitals for treatment, such admission to be made after due examination, investigation and consideration of the individual patient. Chronic alcoholism should not be considered as an illness which bars admission to a hospital, but rather as qualification for admission when the patient requests such admission and is cooperative, and the attending physician's opinion and that of hospital personnel should be considered. The chronic alcoholic in an acute phase can be, and often is, a medical emergency."

Committee on Medical Practices

In approving a progress report of the Committee on Medical Practices, the House amended one of its directives to read as follows in order to remove any legal objectives:

"The A.M.A. representatives on the Joint Commission on Accreditation of Hospitals be instructed to stimulate action by that body leading to the warning, provisional accreditation, or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class regardless of their individual professional competence where such policies adversely affect the quality of patient care rendered. Any action taken should be only after appeal to the Commission by the county medical society concerned."

The House also approved a recommendation by the Committee on Medical Practices that a study group be formed to consider the best background preparations for general practice, and it urged that such action be implemented as soon as practicable.

Miscellaneous Actions

Among many other actions on a wide variety of subjects, the House of Delegates also:

Urged the widest possible publication and

distribution of Dr. Murray's presidential address at the opening session;

Pledged the full support of the Association's initiative and energy to President Eisenhower's people-to-people program as a means of promoting understanding, peace and progress;

Directed the Board of Trustees to continue its investigation of the practicability of developing a statement of A.M.A. policies and to arrange for the periodic publication of revised versions of such a policy statement;

Commended the objectives of the American Association of Medical Assistants and its sincere desire to work closely with the medical profession in improving medical service and medical public relations;

Noted with pride the good work being done by the 74,348 members of the Woman's Auxiliary, as reported to the House by Mrs. Robert Flanders, President;

Directed the Councils on Pharmacy and Chemistry and on Foods and Nutrition to conduct a joint study of all presently available information concerning the fluoridation of public water supplies and to present a documented report of findings and recommendations at the December 1957 meeting;

Urged all physicians to participate actively in the formulation of medical policy for prepaid medical care plans which are under physician direction or sponsorship;

Changed the By-laws to extend service membership to reserve officers on extended active duty with the defense forces and the U. S. Public Health Service;

Changed the By-laws relating to transfer of membership so that an active or associate member of the Association who moves his practice to another jurisdiction may continue his A.M.A. membership by applying for membership in the constituent association in his new jurisdiction, subject to a two year limit on approval of his application;

Changed the By-laws so that the election of officers may take place at any time on the fourth day of the annual session, instead of being restricted to the afternoon of that day;

Passed a resolution calling for the American Medical Association to join with the American Hospital Association and the American Institute of Architects in their proposed study of hospital design and construction;

Approved the principle of a voluntary reduction in the self-assigned quota of interns as printed in the 1956 handbook of the National Intern Matching Program, and

Instructed the Board of Trustees to accentuate cooperation between the American Medical Association and the American Bar Association to the end that a bill of the Jenkins-Keogh type be enacted at the next session of the Congress.

Opening Session

At the Tuesday opening session Dr. Murray, on behalf of the American Medical Association, presented a special citation to Ciba Pharmaceutical Products, Inc., for "the service it has performed to the medical profession and to the nation through its weekly television series, 'Medical Horizons'." At the same session the American Medical Association and four of its constituent societies—California, Arizona, Utah and New Jersey—contributed nearly $300,000 to the American Medical Education Foundation for aid to the nation's medical schools. The A.M.A. announced another gift of $125,000, bringing this year's total contribution to $343,000. The amounts presented by the four states were: California, $132,981; New Jersey, $25,000; Utah, $11,870, and Arizona, $3,695.

Respectfully submitted,
Louis M. Orr, M.D.
Reuben B. Chrisman Jr., M.D.
Francis T. Holland, M.D.

Mediclinics Postgraduate Refresher Course

Fort Lauderdale, March 4-14, 1957

Mediclinics of Minnesota will present the second annual postgraduate refresher course at Fort Lauderdale, beginning on March 4 and continuing through March 14. This course is designed primarily for the general practitioner and will be conducted from 8 to 12 daily throughout the 10 day period. It is sponsored by the Florida Academy of General Practice. The American Academy of General Practice has certified the course for 32 hours of formal postgraduate study, Category I, for the Academy members who attend.

The 32 hours of lectures and panels cover varied subjects in the several fields of medicine. This diversified program will be presented by an able faculty, including Harold F. Buchstein, M.D., Neurosurgery; Thomas P. Cook, B.S.; Harry B. Hall, M.D., Orthopedics; Arthur C.

Kerkhof, M.D., Internal Medicine; Francis W. Lynch, M.D., Dermatology; Ames W. Naslund, M.D., Roentgenology; O. L. Norman Nelson, M.D., Internal Medicine; Owen F. Robbins, M.D., Obstetrics and Gynecology; Albert V. Stoesser, M.D., Pediatrics; Robert J. Tenner, M.D., Proctology; Richard L. Varco, M.D., Surgery; and Edgar A. Webb, M.D., Urology. All are members of the faculty of the University of Minnesota Medical School.

Registration is limited to 300 in order to preserve an informal and intimate atmosphere in the lecture room. The limited enrolment and the time of the meeting at the height of the tourist season make it particularly important that reservations be made early. Send requests for an application to W. J. Glenn, M.D., 1106 East Broward Boulevard, Fort Lauderdale. Dr. Glenn is chairman of the education committee of the Florida Academy of General Practice and is in charge of arrangements for the meeting.

Medical District Meetings, 1956

The Seventeenth Annual Medical District Meetings were held October 30 at Tallahassee, October 31 at Ocala, November 1 at Tampa and November 2 at West Palm Beach. Total registration for the four sessions was 357 members of the Florida Medical Association and 46 visitors.

The medical and surgical treatment of regional ileitis and colitis were the scientific subjects discussed at each of the meetings. The program was arranged by Dr. Herschel G. Cole, of Tampa, chairman of the Council of the Association, with the assistance of the district councilors.

Drs. Fred A. Butler and Earl E. Wilkison, of Tallahassee, were scientific speakers for the meeting in Tallahassee. At Ocala, Dr. Fred Mathers, of Orlando, and Dr. C. Burling Roesch, of Jacksonville, were principal speakers. Dr. John R. Neefe, of St. Petersburg, and Dr. Edmund P. Kelley, of Sarasota, addressed the scientific assembly at Tampa, and Dr. Donald F. Marion, of Miami, and Dr. Charles McD. Harris, of West Palm Beach, the one at West Palm Beach.

Among the prominent guests at each meeting were Dr. George T. Harrell Jr., Dean of the College of Medicine at the University of Florida, and Dr. Homer F. Marsh, Dean of the School of Medicine, University of Miami.

Dr. Cole presided at both the scientific assembly and the general session of each of the four meetings. Assisting him were the district councilors.

At each general session, Dr. John D. Milton, of Miami, Immediate Past President of the Association, discussed the "Proposed Program for Medical Care for Dependents of the Uniformed Services in Florida."

Dr. Francis H. Langley, President; Dr. William C. Roberts, President-Elect, and Dr. Samuel M. Day, Secretary-Treasurer, were present at all the meetings and gave short talks. Dr. Shaler Richardson, Editor of The Journal, reported on progress of The Journal at the meeting in Tallahassee.

Northwest Medical District
October 30—Tallahassee

Dr. Cole presided at the meeting and was assisted during the scientific assembly by Dr. Walter J. Baker, councilor for District 2, and at the general session by Dr. Alpheus T. Kennedy, councilor for District 1.

Dr. Robert H. Mickler, president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, delivered the address of welcome. Following Dr. Mickler's address, Dr. Fred A. Butler discussed "Problems in the Diagnosis and Medical Treatment of Regional Ileitis and Collitis," and Dr. Earl E. Wilkison "Problems in the Diagnosis and Surgical Treatment of Regional Ileitis and Colitis."

The 1957 meeting will be held in Panama City. Total registration was 82, of which 68 were Association members and 14 visitors. Among those attending were past presidents Dr. Shaler Richardson, Dr. John D. Milton, Dr. Herbert L. Bryans and Dr. Julius C. Davis.

Registration

BLOUNTSTOWN: Grayson C. Snyder. BRANFORD: Edward G. Haskell Jr. CHATTAHOOCHEE: Irving T. Clark, William D. Rogers. CRAWFORDVILLE: Thomas D. Head. FOLEY: Walter J. Baker. FORT WALTON BEACH: Frederic E. Caldwell. GAINESVILLE: George T. Harrell Jr. HAVANA: James W. Sapp. JACKSONVILLE: Samuel M. Day, Edward Jelks, James G. Lyerly Sr., James G. Lyerly Jr., Nelson A. Murray, Lorenzo L. Parks, Shaler Richardson LIVE OAK: James A. Horton. MADISON: Wilmer J. Coggins, Wallace E. Winter. MARIANNA: James T Cook Jr, Albert E. McQuagge, William R. Wandeck, Francis M. Watson. MIAMI: John D. Milton. PANAMA CITY: J. Powell Adams, William C. Fontaine,

(Continued on page 698)

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(Continued from page 695)

Joseph H. Morris, William C. Roberts, C. W. Shackelford, Harold E. Wager. PENSACOLA: Bernard M. Barrett, Herbert L. Bryans, Alpheus T. Kennedy, Wendell J. Newcomb, Gretchen V. Squires. QUINCY: Julius C. Davis, Taylor W. Griffin, George H. Massey. ST. PETERSBURG: Francis H. Langley. TALLAHASSEE: Frank E. All, Russell L. Anderson (Col.), Wilmoth H. Baker (Col.), Thomas J. Bixler, Fred A. Butler, Paul J. Coughlin, Laurie L. Dozier, George H. Garmany, Francis T. Holland, Charles F. James Jr., J. Elizabeth Jeffress, Odis G. Kendrick Sr., Odis G. Kendrick Jr., Clarence W. Ketchum, Nelson H. Kraeft, John L. Lincoln, Lillie O. Linton, George H. McCain, David J. McCulloch, Robert H. Mickler, George S. Palmer, Bricey M. Rhodes, Naomi T. Stinger, Frederick B. Thigpen, Robert N. Webster, Wm E. Westcott, Benjamin A. Wilkinson, Earl E. Wilkison. TAMPA: Herschel G. Cole.

VISITING DOCTORS—CHATTAHOOCHEE: Lindsey D. Campbell. PANAMA CITY: Henry C. Smallwood. TALLAHASSEE: James K. Conn, I. Barnett Harrison, George N. Lewis, S. A. Shaffer, Francis H. Watt.

OTHER GUESTS—ATLANTA: Leyton B. Hunter. CORAL GABLES: Homer F. Marsh, Ph.D. JACKSONVILLE: Robert G. Carter, Ernest R. Gibson, Eugene L. Nixon, W. Harold Parham, H. A. Schroder.

Northeast Medical District

October 31—Ocala

Assisting Dr. Cole as presiding officers for the meeting were Dr. Charles L. Park Sr., councilor for District 4, during the scientific assembly, and Dr. Leo M. Wachtel Jr., councilor for District 3, at the general session.

Following the address of welcome by Dr. William J. McGovern, president of the Marion County Medical Society, Dr. Fred Mathers discussed "Problems in the Diagnosis and Medical Treatment of Regional Ileitis and Colitis," and Dr. C. Burling Roesch "Problems in the Diagnosis and Surgical Treatment of Regional Ileitis and Colitis."

A feature of the general session was the address by the Hon. Charles E. Bennett, Congressman from the Second District, who discussed "Recent National Health Legislation."

The 1957 meeting is to be held at Orlando, according to decision reached during the general session. Total registration was 103, of which 92 were Association members and 11 visitors. Past presidents attending were Dr. Edward Jelks, Dr. Frederick J. Waas, Dr. John D. Milton, Dr. Eugene G. Peek Sr. and Dr. Duncan T. McEwan.

Registration

BROOKSVILLE: George R. Creekmore. COCOA: Lee Rogers Jr., A. F. Thomas. DAYTONA BEACH: John J. Cheleden, C. Robert DeArmas, Herbert A. King. DELAND: William R. Hutchinson. EUSTIS: Thomas E. Langley. GAINESVILLE: Edwin H. Andrews, Henry J. Babers Jr., F. Emory Bell, Billy Brashear, Edward G. Byrne, Alva T. Cobb Jr., Allen Y. DeLaney, J. Maxey Dell Jr., George L. Emmel, Raymond J. Fitzpatrick, George T. Harrell Jr., Albert G. Love IV, John E. Maines Jr., Walter E. Murphree, George H. Putnam, Glenn O. Summerlin. HOLLY HILL: Frank A. Sica. JACKSONVILLE: Frederick H. Bowen, Charles W. Boyd, Howard C. Chandler, James E. Cousar III, James M. Davis, Samuel M. Day, Joel Fleet, Ivan Isaacs, Edward Jelks, Elmer E. Leitner, James G. Lyerly Sr., James G. Lyerly Jr., Charles F. McCrory, Nelson A. Murray, Lorenzo L. Parks, C. Burling Roesch, William A. Van Nortwick, Frederick J. Waas, Leo M. Wachtel Jr., Edward C. Watt, Donald P. White Jr., Ashbel C. Williams. LEESBURG: George E. Engelhard, Marion B. O'Kelley. MIAMI: John D. Milton. MOUNT DORA: J. Basil Hall, Fred A. Vincenti. OCALA: William H. Anderson, Hugh H. Barfield, Luther A. Brendle, Richard C. Cumming, T. Hartley Davis, Bertrand F. Drake, Harry S. Gibboney Jr., Robert L. Gibson, Henry L. Harrell, Nathaniel H. Jones (Col.), William J. McGovern, John P. Moore, Eugene G. Peek Sr., Eugene G. Peek Jr., Samual A. M. Shashy, Thos. H. Wallis, Herbert M. Webb Jr., Earl E. Yantis. ORLANDO: Frank C. Bone, Thomas C. Butt, J. Rocher Chappell, Chas. J. Collins, Lawrence H. Kingsbury, Harold W. Johnston, Duncan T. McEwan, Fred Mathers, Roger E. Phillips, Louis E. Pohlman, Frank J. Pyle, Charles R. Sias, Alfred S. Stevenson, Andrew W. Townes Jr., Robert E. Zellner. PANAMA CITY: William C. Roberts. ST. PETERSBURG: Francis H. Langley. SANFORD: Terry Bird, J. Clifford Boyce. TAMPA: Herschel G. Cole. WILLISTON: James Weres. WINTER PARK: Warren A. Brooks.

VISITING DOCTORS: ALACHUA: Jesse A. Goode. JACKSONVILLE: James W. Bond. RAIFORD: Chas. W. Bush.

OTHER GUESTS—ATLANTA: Leyton B. Hunter. CORAL GABLES: Homer F. Marsh, Ph.D. JACKSONVILLE: Charles E. Bennett, Robert G. Carter, Ernest R. Gibson, Eugene L. Nixon, W. Harold Parham, H. A. Schroder.

Southwest Medical District

November 1—Tampa

During the scientific assembly, Dr. Cole was assisted as presiding officer by Dr. C. Frank Chunn, councilor for District 5, and at the general session by Dr. Gordon H. McSwain, councilor for District 6.

Dr. James N. Patterson, president of the Hillsborough County Medical Association, delivered the address of welcome, and scientific speakers were Dr. John R. Neefe who discussed "Problems in the Diagnosis and Medical Treatment of Regional Ileitis and Colitis" and Dr. Edmund P. Kelley whose subject was "Problems in the Diagnosis and Surgical Treatment of Regional Ileitis and Colitis."

At the general session, Clearwater was selected as the meeting place for 1957. Total registration was 143, of which 127 were Association members and 16 visitors. Among those registered were past presidents Dr. Edward Jelks, Dr. David R. Murphy Jr. and Dr. William M. Rowlett.

Registration

ARCADIA: Gordon H. McSwain. BARTOW: Alfred S. Massam. BRADENTON: Eugene E. Biel, Joseph B. Ganey, Joseph A. Gibson, Willis W. Harris, Richard V. Meaney, Millard P. Quillian, Henry E. Rasmussen-Taxdal, William D. Sugg. BROOKSVILLE: S. Carnes Harvard. CLEARWATER: Douglas W. Carr, James V. Freeman, James B. Leonard, William G. Mason, Sherman H. Pace. DADE CITY: W. Wardlaw Jones, John S. Williams. DUNEDIN: John A. Mease Jr., James F. Spindler, Wal-

ter H. Winchester. FORT MYERS: H. Quillian Jones, John S. Stewart. GAINESVILLE: George T. Harrell Jr. JACKSONVILLE: Samuel M. Day, Edward Jelks, Lorenzo L. Parks. LAKELAND: Robert M. Akey, Jere W. Annis, James R. Boulware Jr., Marion W. Hester, James T. Shelden, James R. West, Everett S. King. LAKE WALES: Willard E. Manry Jr. LUTZ: Augustine S. Weekley. PLANT CITY: Richard M. Kafka, Madison R. Pope, Alex F. Sanchez. PUNTA GORDA: Roscoe S. Maxwell. ST. PETERSBURG: Clyde O. Anderson, David K. Davis, Earl R. Fox, N. Worth Gable, Henry J. Jensen, Norval M. Marr Jr., John B. O'Neill, Robert B. Mertz, John R. Neefe, John P. Rowell. SARASOTA: John M. Butcher, Joseph Halton, Edmund P. Kelley, Sherrel D. Patton, Hugh G. Reaves, Karl R. Rolls, Harry O. Specht, Henry J. Vomacka, Samuel R. Warson. TAMPA: Samuel H. Adams, Chadbourne A. Andrews, Efrain C. Azmitia, Collin F. Baker Jr., Ernest R. Bourkard, C. MacKenzie Brown, J. Robert Campbell, Eugene F. Carter Sr., Charles Catanzaro, Frank V. Chappell, C. Frank Chunn, Robert H. Coffer Jr., Herschel G. Cole, Philip G. Creese, Marvin L. Cullen, Rosalind E. Cummings, Joshua C. Dickinson, Robert H. Douglas, R. Renfro Duke, Wm. P. Duncan, Celestino G. Fernandez, Louis J. Garcia, Eugene S. Gilmer Sr., Leo C. Gonzalez, Kenneth G. Gould, Charles McC. Gray, H. Phillip Hampton, Samuel G. Hibbs, Richard S. Hodes, A.M.C. Jobson, Oscar A. Juarez, Warren T. Loftis Jr., Blackburn W. Lowry, Paul J. McCloskey, Myron L. McEachern, Thomas E. McKell, Eugene B. Maxwell, Richard J. Miller Jr., David R. Murphey Jr., Robert G. Nelson, Robert H. Owrey, Hugh E. Parsons, Julien C. Pate Sr., Julien C. Pate Jr., James N. Patterson, Anthony P. Perzia, Lee T. Rector, William M. Rowlett, Mauricio Rubio, Zack Russ, Edward F. Shaver, Marshall E. Smith, Mason C. Smith, Louis A. Spicola, Alan J. Stevenson, Alvord L. Stone, Joseph W. Taylor Sr., Joseph W. Taylor Jr., Ralph S. Torbett, Joseph N. Torretta, William W. Trice Jr., Mason Trupp, Morris Waisman, Frances C. Wilson, Wesley W. Wilson, Robert W. Withers, Dillard B. York Jr. WINTER HAVEN: Chester L. Nayfield.

VISITING DOCTORS—CLEARWATER: James P. Burns Jr., Daniel B. Lowrey. TAMPA: Eugene J. Cornett, James J. Crumbley Jr., Arturo G. Gonzalez, Charles H. Lasley, Helen K. Miller, John T. Wright. ST. PETERSBURG: Howard L. Reese.

OTHER GUESTS—ATLANTA: Leyton B. Hunter. CORAL GABLES: Homer F. Marsh, Ph.D. JACKSONVILLE: Robert G. Carter, Ernest R. Gibson, Eugene L. Nixon, W. Harold Parham, H. A. Schroder.

Southeast Medical District

November 2—West Palm Beach

Presiding with Dr. Cole were Dr. Ralph S. Sappenfield, councilor for District 8, during the scientific assembly, and Dr. Ralph M. Overstreet Jr., councilor for District 7, during the general session.

Dr. Walter R. Newbern, president of the Palm Beach County Medical Society, delivered the address of welcome, and following Dr. Newbern, Dr. Donald F. Marion discussed "Problems in the Diagnosis and Medical Treatment of Regional Ileitis and Colitis." The other scientific speaker was Dr. Charles McD. Harris Jr., who discussed "Problems in the Diagnosis and Surgical Treatment of Regional Ileitis and Colitis."

The 1957 meeting is to be held at Fort Pierce. Total registration was 75, of which 62 were Association members and 13 visitors. Among those registered were past presidents Dr. John D. Milton and Dr. Frederick K. Herpel.

Registration

CORAL GABLES: Jack Q. Cleveland. DANIA: Fred E. Brammer. DELRAY BEACH: Graham W. King Jr. FT. LAUDERDALE: Garland M. Johnson. FORT PIERCE: Alfred J. Cornille, John T. McDermid, Richard F. Sinnott, Maltby F. Watkins. GAINESVILLE: George T. Harrell Jr. HOLLYWOOD: John H. Mickley, Louis J. Novak. JACKSONVILLE: Samuel M. Day, Lorenzo L. Parks. LAKE WORTH: Richard F. Kidder, Arthur T. Rask, Edward W. Wood. MELBOURNE: Jack T. Bechtel. MIAMI: Bernard Abel, L. Washington Dowlen, M. Jay Flipse, Forrest H. Foreman, Donald F. Marion, John D. Milton, Kenneth Phillips, Walter W. Sackett Jr., Herbert W. Virgin Jr. PALM BEACH: Robert M. Alexander, Fred E. Manulis, William H. Proctor, Herman G. Rose, Bailey B. Sory Jr., James R. Sory. PANAMA CITY: William C. Roberts. RIVIERA BEACH: Robert Y. Whelihan. ROCKLEDGE: James R. Doty. ST. AUGUSTINE: Reddin Britt. ST. PETERSBURG: Francis H. Langley. TAMPA: Herschel G. Cole. VERO BEACH: Erasmus B. Hardee. WEST PALM BEACH: Willard F. Ande, James R. Anderson, Robert V. Artola, Horace D. Atkinson, John M. Baber, Herman Baxt, Harry E. Bierley, Edwin W. Brown, Coleman G. Buford, Victor Clarholm, James F. Cooney, Theodore F. Gerson, Charles McD. Harris, Frederick K. Herpel, Oliver L. Jones, Walter R. Newbern, Ralph M. Overstreet Jr., Cecil M. Peek, Raymond R. Preefer, Atwell B. Pride (Col.), Daniel H. Rowe, Murray D. Sigman, Joseph R. Skyer.

VISITING DOCTORS—LAKE WORTH: Calvin M. Cerrato, Samuel S. Wright. PALM BEACH: R. C. Schilling, John van Boven III. RIVIERA BEACH: F. Kevin O'Brien, Richard Q. Penick. WEST PALM BEACH: Joseph C. Doane, Cabell Young Jr.

OTHER GUESTS—ATLANTA: Leyton B. Hunter. CORAL GABLES: Homer F. Marsh, Ph.D. JACKSONVILLE: Eugene L. Nixon, W. Harold Parham. WEST PALM BEACH: John F. Wymer Jr.

OTHERS ARE SAYING

President's Message

At our last County Medical Society Meeting we received the report of our F. M. A. delegates. This and the subsequent question-answer period induced me to write the following brief comments on the purpose and importance of medical society structure at all levels—county, state and national.

The obvious purpose of a medical society is to transact the business and solve the problems of physicians as a group, in the most effective manner. It is still our belief that this is best accomplished on a democratic basis. For this reason, Medical Society organization is patterned after the principles on which our federal, state, and local government is founded.

Functioning in this way the Society offers every member an opportunity to have a voice in all actions of the group. Officers are elected by majority vote. Any member may be nomiated for office. Delegates to the State Society are similarly elected for a three year term, and

they in turn elect delegates to the National society as well as the state officers. I shall elaborate briefly on their functions a little later.

New business can be brought up for consideration of the County Society at any time by any member. Such business can be introduced from the floor, but action is expedited by presenting it as a letter or committee report. All such business properly should be referred to a committee for study. This may be done either through an appropriate standing committee, or one specially appointed for the business at hand. After such study the business is returned to the society as a recommendation or resolution. Action is then taken by the society as a whole.

Should the business introduced be a matter requiring state or national action, it is the function of our delegates to properly introduce it at the state level. They can do this only after our local society has passed a resolution by vote and instructed the delegates to proceed. It does no good, therefore, for the member who attends one or two meetings a year, to complain that one of his particular interests has not been given attention. Each member has an obligation to his society. If he is interested in having something done, he should help work for it. The delegates, officers, and committee chairmen can not do it all. If they are lax, it is the responsibility of the members to do some prodding—but do it constructively, not in the spirit of criticism.

In closing let me mention the other facet of this structure. In a democratic system it is highly desirable that officers be changed regularly. This I feel should not apply to our delegates. It requires about two to three years for a delegate to the State Society to get beyond the "Babe in the Woods" stage. After that period he becomes much more useful to us. It would seem advisable, then, for a delegate to be reelected for several three year terms, unless he is failing to give us adequate representation. In addition, it would be wise to elect and groom alternates to take over when it becomes necessary or expedient to terminate a delegate. In this fashion, and by giving our delegates sound, clear instructions as to our desires, we can achieve the status that a community and society of our size deserve.

Eugene D. Liddy, M.D.
—*The Bulletin,*
Sarasota County Medical Society
July, 1956

CLASSIFIED

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

MEDICAL OFFICE FOR LEASE: New Medical-Dental Arts Building. Air conditioned. Large waiting rooms. Very reasonable lease for the right medical doctors. Write H. W. Tustison, D.D.S., 1000 S. Federal Highway, Fort Lauderdale, Fla.

WANTED: Physician with Florida license. Interest in Physical Medicine and Geriatrics. State qualifications in writing. The Miami-Battle Creek, Miami Springs, Fla.

FOR SALE OR LEASE: Physician's office with good practice. Long established in growing Florida East Coast city. Prefer Southerner interested in general practice. Wonderful opportunity. Write 69-200, P.O. Box 2411, Jacksonville, Fla.

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PHYSICIAN WANTED: General Practitioner to associate with a well established medical clinic in Miami area. Basis of percentage, salary or rental. Salary open, depending on experience and training. Give complete personal and professional data in first letter. Florida license required. Write 69-206, P. O. Box 2411, Jacksonville, Fla.

FOR LEASE: Suite in new modern air-conditioned medical building. Reasonable rate. Wonderful opportunity. Write A. A. Edwards, 2030 Oak Terrace, Sarasota, Florida. Telephone: Ringling 7-3862.

INTERNIST: Board eligible. Florida license. Two years practice, married, 32 years old. Licensed to use radioisotopes. Seeks consultation or hospital type practice. Not interested in "family type" housecall practice. Protestant, nondrinking, Southerner. Write 69-207, P. O. Box 2411, Jacksonville, Fla.

INTERNIST: Board eligible. Florida license. University trained. Private practice experience. Interested in chest and cardiology. Veteran, age 36. Wishes to affiliate with Internist or group. Write 69-208, P. O. Box 2411, Jacksonville, Fla.

WANTED: Association with established doctor. Florida license. Experienced in surgery, obstetrics, orthopedics and general, Middle aged; congenial. Write 69-209, P. O. Box 2411, Jacksonville, Fla.

COMPONENT SOCIETY NOTES

Volusia

Care of the medically indigent was the principal topic for discussion at the November meeting of the Volusia County Medical Society. It was held in the Princess Issena Hotel.

Mr. Robert Carter, of Jacksonville, Administrative Analyst with the Florida State Board of Health, was principal speaker. Dr. Theodore F. Hahn Jr., of DeLand, President of the Society, presided.

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Abernathy, Thomas E., Jacksonville
Allen, Herbert L., Melbourne
Atkins, J. Thomas, Jacksonville
Deen, Duane C., Winter Park
Gyland, Stephen P. Jr., Jacksonville
Heffernan, John A., North Miami
Ivey, John F., Jacksonville
LoPopolo, Vincent C., Cross City
Lundell, Edward S., Jacksonville
Meares, Edward F., Orlando
Monsour, Faris S. Jr., Jacksonville
Moss, James K., Jacksonville
Norris, William B., St. Petersburg
Noyes, Charles E. Jr., Orlando
Omainsky, Walter, Eau Gallie
Reese, Howard L., St. Petersburg
Snider, Kenneth B., Pensacola
Suhrer, Julian G. Jr., Jacksonville
Tippins, H. Keener, Pensacola

BIRTHS, MARRIAGES AND DEATHS

Births

Dr. and Mrs. Leonard Garten, of Jacksonville, announce the birth of a son, David Michael, on September 20, 1956.

Dr. and Mrs. James M. Davis, of Jacksonville, announce the birth of a son, Thomas Palmer, on September 23, 1956.

Dr. and Mrs. Emmet F. Ferguson Jr., of Jacksonville, announce the birth of a daughter, Joann Ruth, on September 15, 1956.

Dr. and Mrs. Benton B. Perry, of Miami, announce the birth of a son, Matthew, on October 4, 1956.

Dr. and Mrs. Herman Cohen, of Miami Beach, announce the birth of a daughter, Mona Carole, on October 8, 1956.

Marriages

Dr. Benjamin F. Hart, of Fort Lauderdale, and Miss Elizabeth H. Tienken, of Wilmington, N. C., were married October 5, 1956, in Fort Lauderdale.

Deaths—Members

Howard, Harvey J., Clearwater ..... November 6, 1956
Hughes, Ray W., Lake Worth ..... August 29, 1956

Deaths—Other Doctors

Kenneth, Milena Anna, North Miami ..... June 30, 1956
Parker, John Henry, Tampa ..... May 22, 1956
Ward, Cassius A. (Col.), Jacksonville ..... June 22, 1956
Thorpe, Eugene Davis, Madison ..... May 16, 1956
Moore, Leland O. W., Washington, D. C. ..... Aug. 28, 1956
Maechtle, Everett W., Evanston, Ill. ..... October 28, 1951
Laymon, Russell L., Bunnell ..... November 9, 1956
Schlesinger, Jacob, Hammond, Ind. ..... March 14, 1956
Stephenson, Gordon A., Summit, N. J. ..... May 4, 1956
Shaw, John S., Jr., Wilmington, Del. ..... November 21, 1949
Nash, Harold C., Sudbury, Ontario ..... Nov. 1, 1955

STATE NEWS ITEMS

The eleventh annual University of Florida Midwinter Seminar in Ophthalmology and Otolarynogology is being held January 14-19 at Miami Beach in the Hotel Seville. On January 16, the Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology is being held in the same hotel.

Many distinguished ophthalmologists and otolaryngologists from throughout the nation are on the program for the Seminar. Featured speaker on the Society's scientific program is the Surgeon General of the Air Force, Major General Dan C. Ogle.

Dr. John E. Burch of Miami has completed a postgraduate course in cerebral palsy held at the Columbia Presbyterian Medical Center.

Dr. C. Ashley Bird of Jacksonville has returned from Chicago where he attended the Congress of Neurological Surgeons.

Dr. David D. Bennett Jr. of Callahan has been elected president of the newly organized Callahan Chamber of Commerce.

Dr. Sidney Davidson of Lake Worth has been reappointed governor for the state of Florida of the American Diabetes Association. The appointment is for the 1956-57 organizational year.

Drs. W. A. D. Anderson and Carlos P. Lamar of Miami were among the physicians from Florida who attended the two day symposium on "Endocrines and Cancer" held in New York City.

Dr. Louis N. Katz, Director of Cardiovascular Research at Michael Reese Hospital, Chicago, has been visiting the University of Florida College of Medicine as a part of his duties as president-elect of the American Physiological Society. While on the campus, he delivered a lecture on "Recent Advances in Atherosclerosis" in the auditorium of the J. Hillis Miller Health Center.

Drs. John J. Farrell and James F. Gallagher of Miami were principal speakers at the recent meeting of the Miami Obstetric and Gynecologic Society.

Dr. Ralph S. Sappenfield of Miami has been chosen president-elect of the American Society of Anesthesiology.

Dr. Clifford E. L. McIntyre of Fort Lauderdale addressed a recent meeting of the Belle Glade Woman's Club.

Drs. William C. Blake and James A. Winslow Jr. of Tampa have returned from Nassau where they attended the meeting of the American College of Physicians. Dr. Blake is governor for Florida of the College.

Dr. Douglas G. Scott of Jacksonville Beach has been elected lieutenant governor of Kiwanis District 3 which includes the northeast section of the state.

Dr. Samuel E. Kaplan of Venice has returned from Chicago where he has been attending the Cook County Graduate School of Medicine.

Dr. Fred E. Manulis of Palm Beach attended the annual meeting of the American College of Gastroenterology held recently in New York City.

Dr. Thomas H. Bates of Lake City has been honored by the Rotary Club there as one of the city's outstanding citizens. Especial honor was paid Dr. Bates in a tribute presented to the Club at one of its recent meetings.

Drs. James A. Winslow Jr. and Joseph C. Flynn of Tampa attended the annual meeting and scientific sessions of the American Heart Association held at Cincinnati.

Dr. Thomas D. Head of Crawfordville discussed cancer at a November meeting of the Woman's Club of that city.

Dr. Ruth W. Rumsey of Miami was the principal speaker at the recent district meeting of the American Women's Medical Association held at Fort Lauderdale.

Dr. Charles McD. Harris Jr. of West Palm Beach has been elected president of the Florida Division of the American Cancer Society. Dr. Dale E. York of Pensacola has been chosen first vice president, and Dr. Joseph J. Zavertnik of Miami third vice president.

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March 11, 12, 13, 14, 1957

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J. Edward Berk, M.D., Detroit, Mich.
Gastroenterology
Erle Henriksen, M.D., Los Angeles, Calif.
Gynecology
Ovid O. Meyer, M.D., Madison, Wis.
Internal Medicine
Irvine H. Page, M.D., Cleveland, Ohio
Internal Medicine
Barnes Woodhall, M.D. Durham, N. C.
Neurosurgery
John E. Savage, M.D., Baltimore, Md.
Obstetrics
C. Dwight Townes, M.D., Louisville, Ky.
Ophthalmology
Don King, M.D., San Francisco, Calif.
Orthopedic Surgery
Glassell S. Fitz-Hugh, M.D., Charlottesville, Va.
Otolaryngology
Malcolm B. Dockerty, M.D., Rochester, Minn.
Pathology
Sydney S. Gellis, M.D., Boston, Mass.
Pediatrics
Karl Zimmerman, M.D., Pittsburgh, Penna.
Proctology
Laurence L. Robbins, M.D., Boston, Mass.
Radiology
Danely P. Slaughter, M.D., Chicago, Ill.
Surgery
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*Roentgenograms courtesy of I. Richard Schwartz, M.D., Kings County Gastrointestinal Clinic, Brooklyn, N.Y.

SEARLE

The Fourth Interim Congress of the Pan American Association of Ophthalmology is being held in New York City April 7-10, 1957. The annual meeting of the National Society for the Prevention of Blindness is being held jointly with the Congress. Headquarters are the Hotel Statler.

Dr. Francis N. Cooke of Miami presented a paper entitled "Blood Vessel Replacement Therapy" at the Third Latin American Congress of Angiology held in Havana, Cuba, late in 1956.

Courses in "Surgery in Acute Trauma" are to be conducted April 1-3, 1957, at the Walter Reed Army Medical Center, Washington, D.C.; Fitzsimmons Army Hospital, Denver, Colo.; Letterman Army Hospital, San Francisco, Calif.; Valley Forge Army Hospital, Phoenixville, Pa.; William Beaumont Army Hospital, Tacoma, Wash., and Tripler Army Hospital, Hawaii. The course is also being conducted May 6-8, 1957, at the Brooke Army Medical Center, Fort Sam Houston, Texas. Civilian physicians interested in attending any of these courses may apply by writing directly to the commander of the hospital where the course is being conducted.

Dr. Richard A. Henry of Brooksville was principal speaker at the recent meeting of District No. 26, Florida State Nurses Association, held at Brooksville. His subject was anesthesia.

Dr. Orville L. Barks of Sanford and Dr. J. Rocher Chappell of Orlando have returned from Chicago where they attended the Medical Civil Defense Conference.

Dr. T. Vernon Finch of Sarasota and Dr. Alfons R. Bacon of Bradenton attended the recent meeting of the American College of Obstetricians and Gynecologists held in Chicago.

The 1957 meeting of the Southern Medical Association will be held November 11-14 at Miami Beach. All scientific activities of the meeting are to be under one roof, utilizing the facilities of the Miami Beach Municipal Auditorium.

Dr. Jack A. Sloane, currently Assistant Chief of Urology Service at the Second General Army Hospital at Landstuhl, Germany, was recently one of the speakers at the Annual European Medical and Surgical Conference. The title of his address

(Continued on page 711)

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Collateral ligament strains
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Radiculitis
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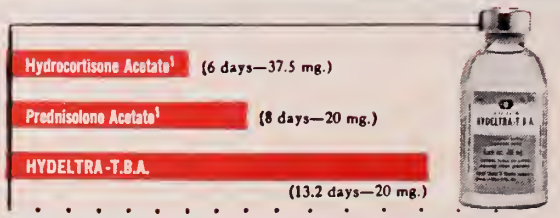

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Fibrositis
Tensor fascia lata syndrome
Collateral ligament strains
Radiculitis
Osteochondritis
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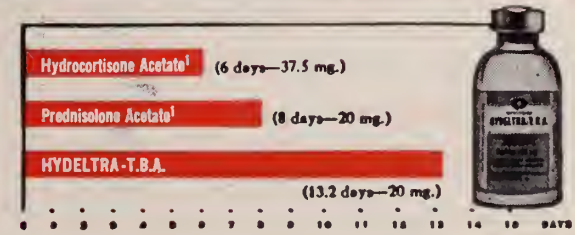

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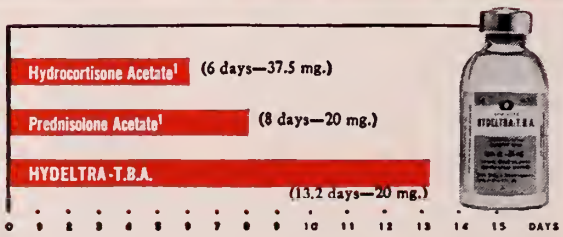

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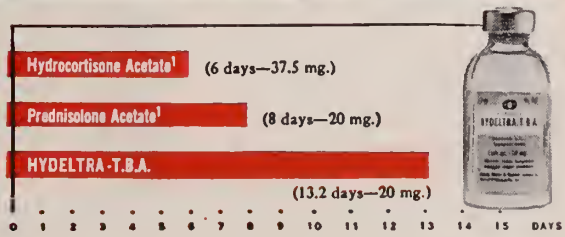

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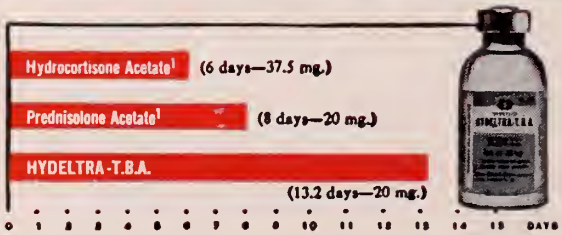

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1. Hollander, J. L., *Paper read at conference in New York City, May 31 and June 1, 1955*

(Continued from page 704)

was "The Management of Renal Injuries." Dr. Sloane formerly resided at Miami.

The International Congress on Circulation is being held June 3-7, 1957, in the Royal College of Surgeons, London. The range of subjects covers every aspect of circulation and the program lists speakers not only from England but America, Germany, France, Sweden, Canada and Scotland as well. Details are available from Congress Secretary, 11 Chandos Street, Cavendish Square, London, W.I., England.

A four day sectional meeting of the American College of Surgeons is being held February 4-7, 1957, in New Orleans at Hotels Roosevelt and Jung. The program includes panel discussions, symposia, scientific papers, cine clinic films in general surgery, and separate programs in the specialties of urology, opthalmology, obstetrics-gynecology, otolaryngology, thoracic surgery and orthopedic surgery.

OBITUARIES

Ray W. Hughes

Dr. Ray W. Hughes of Lake Worth died unexpectedly at his ranch near that city on Aug. 28, 1956. He was 66 years of age.

Dr. Hughes was born in Augusta, Mich., on July 29, 1890. He received his medical training in Detroit, where he was awarded the degree of Doctor of Medicine by Wayne University College of Medicine in 1918. After spending a year as house officer at the Harper Hospital in that city, he served with distinction for three years in the United States Army during World War I.

Upon separation from the service in 1919, Dr. Hughes was associated for several years with two outstanding eye, ear, nose and throat specialists in Detroit, Dr. Herman Sanderson and later Dr. Harold Wilson. Thereafter, he conducted his own practice in ophthalmology and otolaryngology in Detroit for over 20 years. In 1945 he was licensed to practice in Florida and located in Lake Worth, where he had since that time won an enviable place for himself professionally and in public esteem.

Since 1946 Dr. Hughes had been a member of the Palm Beach County Medical Society and the Florida Medical Association. He also held membership in the American Medical Association, the

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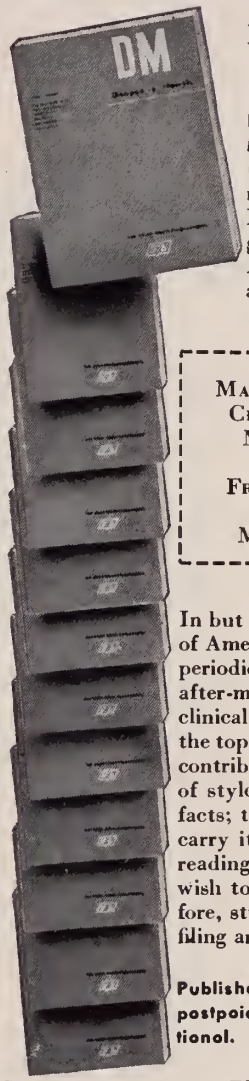

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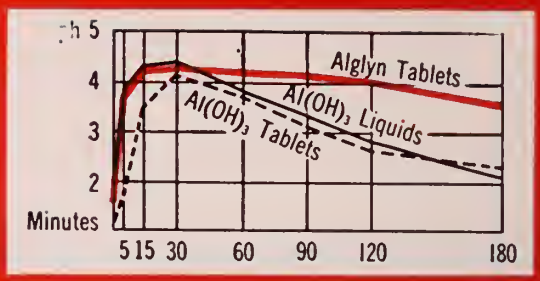

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Alglyn Tablets, 0.5 Gm. dihydroxy aluminum aminoacetate, are supplied in bottles of 100 (white). Your patients will welcome the change from liquid antacid preparations to easy-to-take convenient, lightly-flavored Alglyn Tablets[1].

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Reprint of recent *in vivo* studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 38:586, 1949.

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Detroit Ophthalmological Society, the Detroit Otological and Rhinological Society, and the American Academy of Ophthalmology and Otolaryngology. He was certified by the American Board of Otolaryngology.

Surviving are the widow, Mrs. Bertha C. Hughes, of Lake Worth, and a son, Charles C. Hughes, of Ponca City, Okla.

John Jett McGuire

Dr. John Jett McGuire of Pensacola died unexpectedly at his home on July 1, 1956. He was 61 years of age. Interment took place in Magnolia Cemetery at DeFuniak Springs.

Dr. McGuire was a native of Florida. He was born in DeFuniak Springs on Feb. 4, 1895, and attended the public schools of Walton County. He received his academic schooling at Virginia Military Institute and his medical training at the Tulane University School of Medicine, where he was awarded the degree of Doctor of Medicine in 1919.

Prior to locating in Pensacola in 1931 as a radiologist, he had engaged in the general practice of medicine in DeFuniak Springs and, jointly with Dr. J. C. McSween, had operated a hospital there. He had also practiced for a time in Albuquerque, N. Mex. He came to Pensacola when the city was without a radiologist and rendered the services of his specialty there for a quarter of a century. Locally, he was a member of the Gadsden Street Methodist Church.

Dr. McGuire was a member of the Escambia County Medical Society. For 30 years he had held membership in the Florida Medical Association and was a member of the American Medical Association. He was a diplomate of the American Board of Radiology, a fellow of the American College of Radiology and a member of the Radiological Society of North America. He was a past president of the Florida Radiological Society and had also served as its secretary.

Survivors include the widow, Mrs. Beatrice L. McGuire, of Pensacola; two daughters, Mrs. Harvey L. Broyles, of Harlingen, Texas, and Mrs. Peter V. Speek, of Whittier, Calif.; the mother, Mrs. E. L. McGuire, of Albuquerque, N. Mex.; four sisters, Mrs. Wayland Crisp and Mrs. P. L. Boutz, of Albuquerque, Mrs. W. B. Prince, of Espanola, N. Mex., and Mrs. Henry Culley, of Santa Barbara, Calif.; and four grandchildren.

(Additional Obituaries may be found on page 717)

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Phenobarbital	48.6 mg. (¾ gr.)	48.6 mg. (¾ gr.)

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Leonard Hudson Conly

Dr. Leonard Hudson Conly of Key West died at his home of coronary thrombosis on July 11, 1956. He was 55 years of age.

Born on Aug. 24, 1900, in Gloverville, N. Y., Dr. Conly received his early education in the public schools of Brooklyn, N. Y. He attended the University of Pennsylvania and received his medical degree from the Jefferson Medical College of Philadelphia in 1926. After interning at Northwestern Hospital in Philadelphia and at Mary Immaculate Hospital in Jamaica, Queens, New York, he practiced general medicine and surgery in Brooklyn. There he was on the staff of the Kings County Hospital, the Hamilton Hospital and the Swedish Hospital.

In 1940, Dr. Conly accepted a position with the Veterans Hospital at Fort Howard, Md., as a heart specialist. He resigned nine months later and came to Florida for a complete rest. At the outbreak of World War II, while the ship on which he had sailed to Africa as ship's doctor was on the return voyage, it was torpedoed off Cape Hatteras, and he spent two days in a lifeboat before being rescued. He resumed his practice in Brooklyn and served on a selective service board there. For health reasons he soon decided to return to Florida permanently. Washington authorities requested him to move to Key West which he did in 1944, and he had since that time engaged in general practice there.

Locally, Dr. Conly became the first physician to practice at Monroe General Hospital. He was a member of many organizations, including the Masonic orders, Mahi Temple, and Key West Shrine, Royal Order of Jesters, and the Key West Yacht Club, Rotary Club and Elks Club. He retained membership in the Crescent Club of Brooklyn.

Dr. Conly was a member of the Monroe County Medical Society, and since 1945 had held membership in the Florida Medical Association. He was also a member of the American Medical Association.

Surviving are the widow, Mrs. Evelyn K. Conly; his mother, Mrs. P. M. Conly, of New York; two sons, Patrick and Leonard Jr.; two daughters, Nancy and Carol; two brothers, Leland and Hugh, of New York; and two sisters, Miss Ruth Conly, of New York, and Mrs. Eileen Winter, of London, England.

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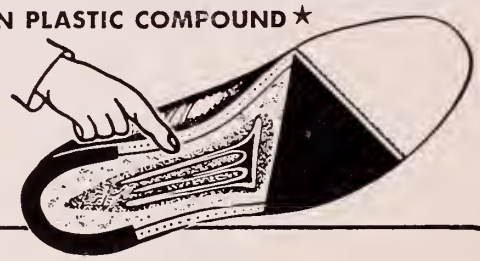

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Auxiliary Hard at Work

It seems the auxiliaries just begin their work when along comes the holiday season, with children at home and the extra work of Christmas and the New Year. However, this time to draw a breath from auxiliary activities aids the work, just as a long vacation does to a person such as our husbands who sometime stay on the job too long without a breather. January brings extra effort for the remainder of our auxiliary year, terminating with the convention.

With the holidays behind us, we can look forward to five months of intensive work so that Florida will again be recognized as one of the outstanding state auxiliaries at the national convention in June.

We hope you won't misunderstand—work in the auxiliary does not come to a complete standstill during December—it just slows down enough to give us added steam to make the latter half of our year one big activity with glowing results.

Mrs. Scottie J. Wilson, President, is beginning to visit the county auxiliaries and, with her enthusiasm and knowledge of the program, is help-

Doctor, would it be helpful to you in your practice to know that there is a food available at reasonable prices in the stores the year round having these attributes:

1. High public acceptance as to flavor and palatability—billions eaten annually.
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9. Can be used as an ingredient product in breads, pies, cakes and desserts.
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11. Mildly laxative.
12. May be used in the management of both diarrhea and constipation.
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15. Useful in the dietary management of celiac disease.
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19. Belongs among foods useful in certain acute intestinal infections.
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21. Favorably influences mineral balance.
22. Useful in the management of ulcer diets.
23. One of the easiest foods to eat or prepare.

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ing the auxiliaries gather their steam for the final five months push. The district meetings, with both Mrs. Wilson and Mrs. Perry D. Melvin, President-elect attending, gave another opportunity for interpretation of the program. Both reported outstanding meetings, good attendance, and the opportunity for members to discuss their problems and obtain information.

The various committees of the Woman's Auxiliary to the Florida Medical Association are hard at work and the results will show in their reports for the convention the first of May. The special committees on organizational matters are functioning and will have their work completed by convention time.

Mrs. Melvin, who is also Counselor for the Southern Medical Auxiliary in Florida, reports a fine meeting in Washington of the Auxiliary. Mrs. O. W. Robinson, Paris, Texas, has become the new president of that group and Mrs. Walker Curtis, College Park, Georgia, was made president-elect. Mrs. Robinson is already busy with her program for this year. Mrs. Melvin continues as Counselor and Mrs. W. P. Smith, Coral Gables, accepted the chairmanship for program. We can look forward to having the Southern Medical Association and its auxiliary as our guests in Florida next year, since their annual meeting will be held in Miami Beach.

Doctor's Day, a southern auxiliary project, is just around the corner being held on March 30 of each year or as near that date as possible. Plans are in the making at both the state and county levels for events honoring doctors throughout Florida. I think we can look for a big showing in this event from all our county auxiliaries as well as from the state.

Benefits and individual donations for the AMEF are beginning to show up and we hope to have raised no less than $2,500 by the end of our year. Subscriptions to Today's Health are increasing every month and we urge every doctor to take advantage of the professional subscription rate for his office when one of our members calls on him.

Programs are planned in many of our county auxiliaries on our state needs and, with our state legislators present, we hope to have the opportunity to question them on proposed health legislation to be taken up when they meet in April. Many of the county auxiliaries are participating in and helping plan safety campaigns in their localities and programs for Mental Health Week which comes the first week in May.

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A Better Antihypertensive

. . . because among all Rauwolfia preparations Rauwiloid (alseroxylon) is maximally effective and maximally safe . . . because least dosage adjustment is necessary . . . because the incidence of depression is less . . . because up to 80% of patients with mild labile hypertension and many with more severe forms respond to Rauwiloid alone.

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. . . because Rauwiloid's *nonsoporific* sedative action relieves anxiety in a long list of unrelated diseases not necessarily associated with hypertension . . . without masking of symptoms . . . without impairing intellectual or psychomotor efficiency.

Dosage: Simply two 2 mg. tablets at bedtime.
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Riker LOS ANGELES

Benefits and individual contributions are being augmented for our nurses loan funds in order to help obtain students for medicine's allied professions. Emphasis is being placed on the need for hospital nurses.

Civil Defense films are being shown and cooperation with the Civil Defense Committees in our counties is being offered. Many of our members are helping train people in first aid and home nursing. First aid kits for the home and automobiles are being prepared and many members are participating in the "Grandma's Kitchen" program of having sufficient food on hand, properly packed, to care for their families in case of bomb attack or other disaster.

As of this writing, 1957 looks like our most hopeful year as far as progress and concrete advance in our programs is concerned. Our optimism is undimmed and our thoughts are not on just what we are doing today but on the future and the continued advance of our auxiliary in its aim of friendly relations between doctors' families and of help in the betterment of health in the state of Florida.

Mrs. Richard G. Stover.

BOOKS RECEIVED

Dictionary of Poisons. By Ibert Mellan and Eleanor Mellan. Pp. 150. Price, $4.75. New York, Philosophical Library, 1956.

This volume is to be recommended to everyone who may be called upon to render first aid to a victim of poison. It is estimated that approximately 34,000 Americans are killed in the home each year, of whom fully one third die of poisoning. This book fills a great need, for the material is presented in clear and concise form and in language which everyone can understand. Following a brief history of poisons as suicidal agents, there is a discussion of emergency treatment, the removal of ingested poisons, the method for preparing antidotes, and a listing of demulcents, cathartics and stimulants. Each type of poisoning is described with regard to its nature, occurrence, symptoms, antidotes and first aid treatment.

Hunterdon Medical Center. The Story of One Approach to Rural Medical Care. By Ray E. Trussell, M.D. Pp. 236. Price, $3.75. Published for The Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1956.

Here is the story of a medical center, established by the 40,000 residents of Hunterdon County, N. J., a rural community, who paused to study their medical and health needs and finally developed a center with a county-wide program embracing many noteworthy features. The author, Dr. Ray E. Trussell, who was director of the Center for five crucial years while it was being established and put into operation, here describes the project from the first proposal in 1946 through the evolution of the community's goal from a conventional hospital to a true medical and health center designed to serve the county's needs. The heroic and successful efforts to raise

(Continued on page 734)

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prednisolone and hydroxyzine

provides the anti-rheumatic, anti-inflammatory action of the most effective steroid, STERANE,® complemented by the superior central tranquilizing effects of ATARAX.® Minimal disturbance of fluid and electrolyte metabolism; no mental fogging or major toxicity in ataractic action.

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Erythromycin in Treating Pneumonia

A 27-year-old man, a chronic alcoholic, was admitted with a history of an alcoholic spree followed by a cough, greenish sputum and chills and fever.

Physical examination showed a temperature of 104 F. and indicated pneumonia in the right lower lobe. This was confirmed by X-ray. The sputum revealed gram-positive diplococci and blood culture subsequently grew Type VII pneumococci.

The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 48 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.[1]

First Antibiotics Symposium, we reported the successful treatment with thromycin of *H. influenzae* pneumonia and bacteremia. A second patient with *H. influenzae* pneumonia and bacteremia had a clinical course almost identical to the one previously reported, with cure obtained by treatment with 500 mg. of erythromycin per os every four hours for 14 days.

Of these 132 patients with bacterial pneumonia, 127 (96%) had a good clinical result. One patient with lobar pneumonia

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In one investigation, 75 adult patients with bacterial pneumonia were treated with erythromycin. In his summary, the clinician reported: "It is concluded that erythromycin is highly effective in the treatment of pneumonia due to gram-positive bacteria."[2]

This, of course, is only one of many reports showing the effectiveness of ERYTHROCIN against coccic infections. You'll get the same good results (nearly 100% in common, bacterial respiratory infections) when you prescribe ERYTHROCIN. Abbott

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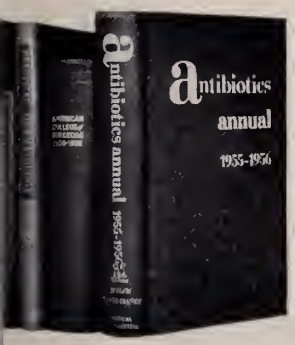

1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48.
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M. A.M.A. Archives of Internal Medicine, 1954, p. 556.

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Pentylenetetrazol . . 100 mg.
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1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954

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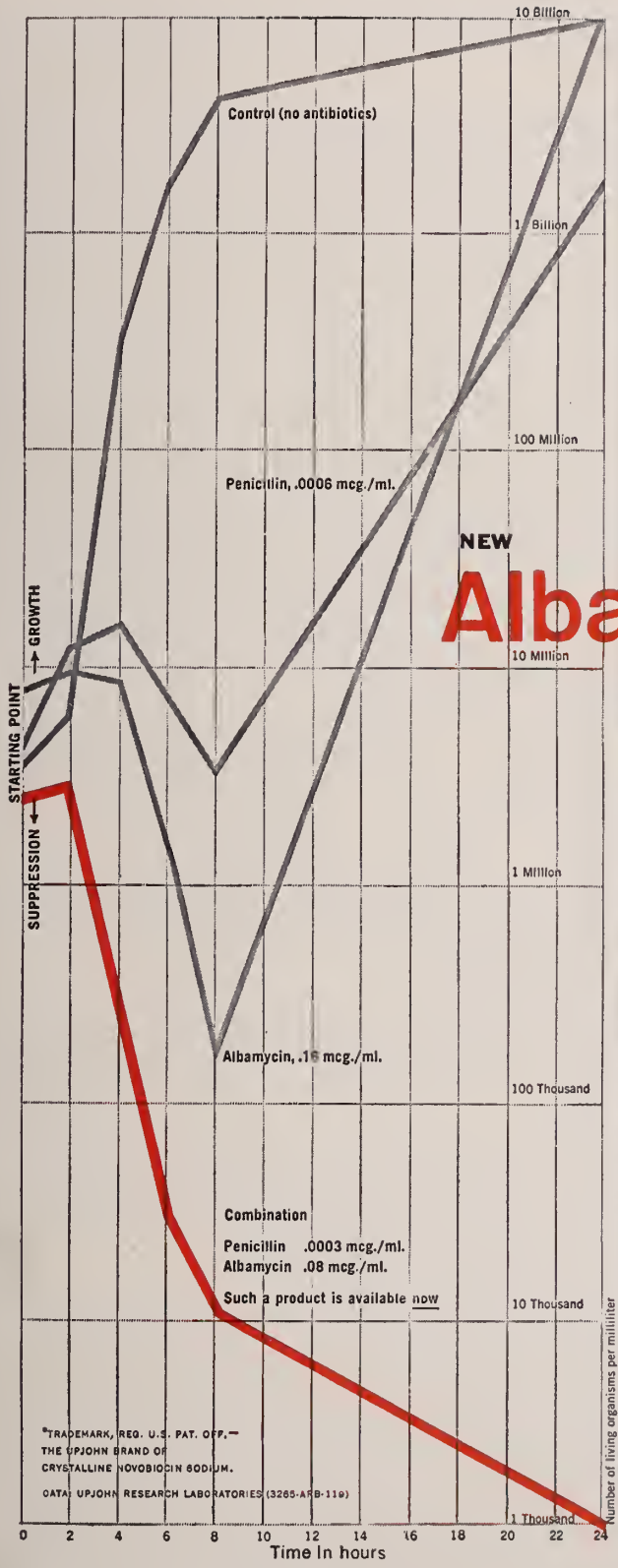

average dosage only t.i.d.

antibiotic synergism

The three gray lines of this graph show the growth rate of a penicillin-sensitive strain of Staphylococcus (Micrococcus pyogenes, var. aureus) under 3 conditions:

1. In the absence of antibiotics
2. In the presence of subinhibitory concentration of penicillin
3. In the presence of subinhibitory concentration of Albamycin*

Even half these subinhibitory concentrations of penicillin and Albamycin, **when combined,** (black line) produce a dramatic **bactericidal** effect.

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Alba-Penicillin*

(Albamycin plus penicillin)

Compare it with the antibiotic you are currently using:

Range of effectiveness: Alba-Penicillin is effective against the organisms that cause the overwhelming majority of bacterial infections (Staphylococci, Streptococci, Pneumococci, Proteus).

Risk of resistance: Because in vitro tests show this combination is synergistic against even Staphylococci already resistant to all other antibiotics, the risk of resistance is minimized.

Risk of enterocolitis: Because it has little or no effect on the predominant Gram-negative intestinal bacteria, and is highly effective against Staphylococci, there is virtually no danger of enterocolitis due to alteration in intestinal flora, or of other side effects such as perianal pruritus.

Convenience: Alba-Penicillin is oral therapy, and the average adult dosage is only **1 to 2 capsules t.i.d.,** which eliminates middle-of-the-night medication.

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erapeutic, *bactericidal* blood levels are
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e.

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tibiotic-induced enteritis, vaginitis or
tis have been reported following
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—for these clinically important infections: tonsillitis; pharyngitis; pneumonia; otitis media; cervical lymphadenitis; streptococcal sore throat; infected tooth sockets; Vincent's infection; acne and superficial skin infections; impetigo; boils, furuncles and carbuncles; lung abscess; bronchitis; mastitis; osteomyelitis; wound infections; postoperative wound infections and infected lacerations; staphylococcal enteritis, staphylococcal diarrhea of the newborn; peritonitis (caused by susceptible organisms); pelvic inflammatory disease; gonorrhea; gonococcal arthritis; urethritis; scarlet fever; erysipelas.

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In one prescription the one antibiotic product most likely to be effective

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(Continued from page 724)

funds, which were of staggering dimensions for a farming community, and the opening and first two years' operation of the Center also are fully described.

Already, the Center has more than fulfilled its reputation as one of the most unusual projects in the chronicles of medical care in this country. It represents a new formula for medical service in a rural community. Its staff of able specialists, all on salary, also hold academic positions in medical schools. The rural hospital is affiliated with a great university medical center. General practitioners serving the county are appointed to the staff of the hospital where they share responsibility for their patients with the full time specialists. A mental health program permeates all of the Center's activities, and a program of preventive medicine seeks both to cure disease by early recognition and to forestall illness. This Commonwealth Fund book will be of particular interest to hospital administrators and other personnel, trustees, medical specialists, general practitioners, public health workers, nurses, and those of the lay public who are concerned with health and medical service particularly in nonmetropolitan areas.

In the Doctor's Office. The Art of Being a Medical Assistant. By Esther Jane Parsons. Ed. 2. Pp. 326. Price, $3.95. Philadelphia, J. B. Lippincott Company, 1956.

Receptionists, medical secretaries, nurses and laboratory technicians who seek to know how they can best serve the doctor and his patients, and physicians who wish their assistants to know, will find the information they seek in this book. It shows the many ways in which medical assistants can increase their personal efficiency, and thus become more valuable to physicians.

The author, a former medical assistant and teacher of assistants, has drawn upon her wide and practical knowledge of medical office practices to present one of the most concise yet complete guides for the medical assistant. A completely new chapter, Mind Over Matter, presents the special situation in psychiatric practice. Much of the material in the book is based on lectures given by Miss Parsons to medical assistants in training. It contains not only her personal observations, based on experience, but practical advice and suggestions actually submitted by physicians and their assistants.

Bellevue Is My Home. By Salvatore R. Cutolo, M.D. with Arthur and Barbara Gelb. Pp. 317. Price, $4.00. New York, Doubleday & Company, Inc., 1956.

This story of one of the world's greatest hospitals is told by its Deputy Medical Superintendent, who has lived with it and loved it for a quarter of a century. It is an inspiring account of tragedy and triumph, of despair and hope, replete with human interest appeal and told with humor and warm respect.

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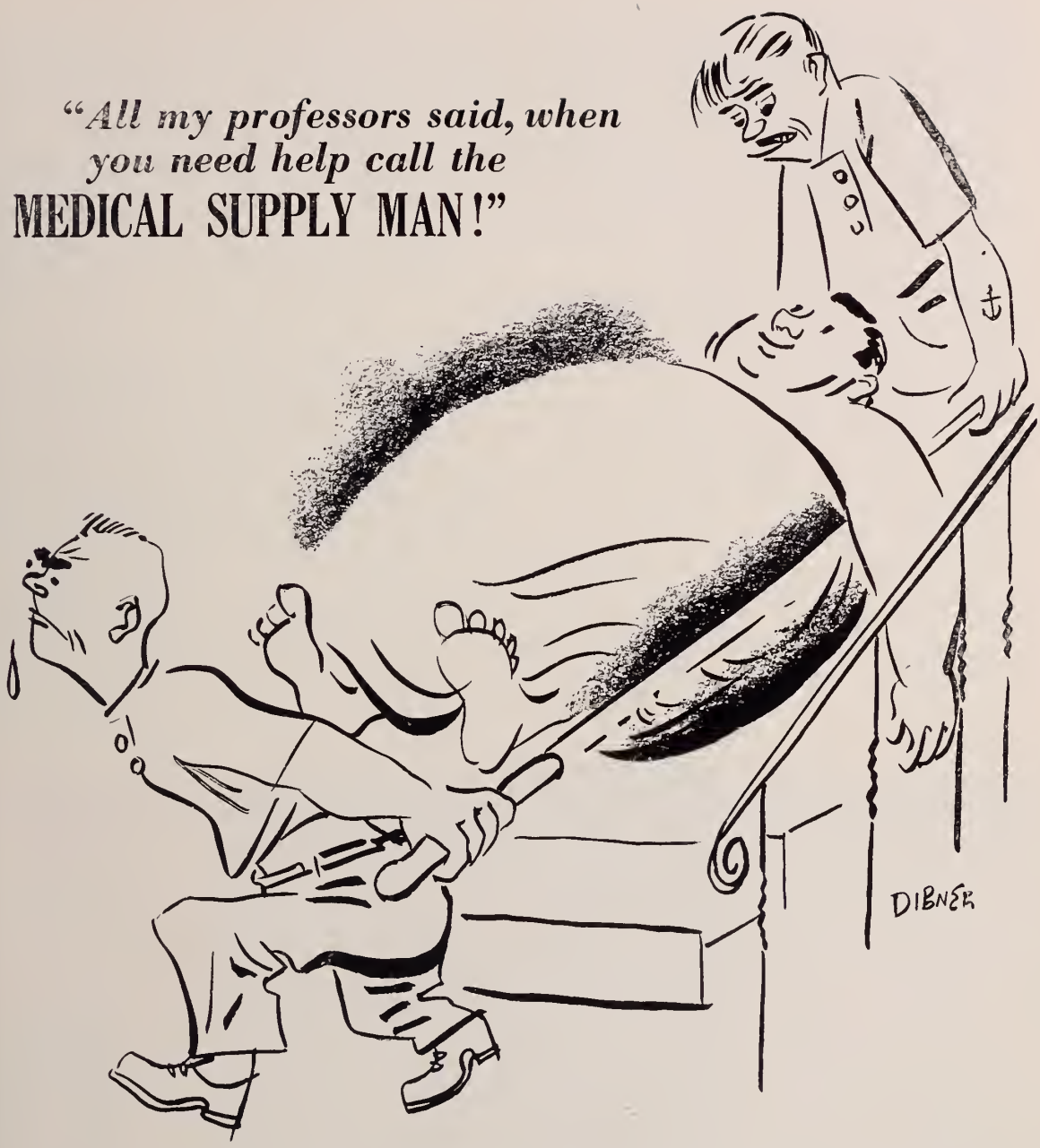

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religion in this great hospital that serves people of all faiths. This great story of the doctors and nurses and patients who work, live, and die in Bellevue Hospital, citadel of hope for eight million people, makes fascinating reading.

Health and Travel. MD International Symposia, No. 1. Pp. 70. Price, $3.00. New York, M D Publications, Inc., 1956.

The proceedings of the First International Symposium on Health and Travel are here presented. This symposium marks a milestone in medical history by creating a new branch of medicine: Travel Medicine. The papers and discussions contain a wealth of sound advice, not available elsewhere, for the general practitioner, internist, pediatrician and gynecologist. The gastrointestinal and cardiovascular systems are thoroughly explored, and the special needs of women and the young, aged and ill are brought into focus. In addition, the clinical problems raised by travel, such as motion sickness and motion sensitivity, are presented, together with descriptions of their successful treatment. The reader will find the proceedings of practical, historical, clinical and sociologic value and also of literary and scientific interest.

Laboratory Tests in Common Use. By Solomon Garb, M.D. Pp. 160. Price, $2.00. New York, Springer Publishing Company, Inc., 1956.

This small concise book on laboratory tests for those not working in the laboratory has a wide range of usefulness. It consists of a text part and two extensive series of tables. The text describes the 120 tests most commonly ordered by physicians. The author, who is assistant professor of clinical pharmacology at Cornell University Medical College, does not aim at the physician directly, but at the nurse or office assistant on whom the physician depends.

Convenient pocket size with flexible binding, this book gives the reasons why a particular test is ordered; shows how it measures function; tells what specimen is needed and exactly how it is collected; spells out the precautions to be taken, considering the patient, the nurse, and others; summarizes what is done in the laboratory and specifies normal ranges for all tests. In the text, the tests are grouped according to the specimen employed, then listed in supplementary tables according to the organ or system whose function is measured. A second series of tables gives quick information that is needed in daily practice, such as how much material each test requires, what type of container is used; whether an anticoagulant is added, and what the normal ranges of tests are. Also given are units of measurements used in the clinical laboratory, the care of needles and syringes, and the technic of venipuncture.

The Rochester Regional Hospital Council. By Leonard S. Rosenfeld, M.D., M.P.H., and Henry B. Makover, M.D. Pp. 204. Price, $3.50. Published for The Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1956.

The Rochester Regional Hospital Council has attracted much attention as one of the most significant experiments in developing hospital service on a regional basis. This widespread interest convinced the Commonwealth Fund that a report of the experiment should be available for the benefit of those unable to visit Rochester to study the program in person. Accordingly, an impartial outside agency, the Institute of Administrative Medicine of Columbia University School of Public Health, was asked to prepare a detailed account and an evaluation of the program.

This book presents that report. It recounts the progress of the Rochester project, which was started in 1946 in an effort to determine in what ways, and to what

extent, concerted voluntary action by hospitals through a representative regional organization might stimulate and encourage an improvement in the quality of services rendered and make possible more efficient and coordinated use of the region's medical facilities. The program included the joint planning of hospital building and expansion; the joint operation of institutional services which can be performed more efficiently by a group than by individual institutions; and the pooling of clinical, administrative, and technical skills.

Another notable Commonwealth Fund book, this full account and unbiased evaluation of the Rochester Regional Hospital Council and its activities will interest all who are concerned with the maintenance and improvement of hospital service.

The Yearbook of Modern Nursing. Edited by M. Cordelia Cowan. Pp. 446. Price, $5.95. New York, G. P. Putnam's Sons, 1956.

This source book of nursing is the first of its kind ever to be published. The range of topics is broad, and the scope of coverage in some instances is worldwide. This first annual résumé of nursing covers both the progress being made and implications for advancement, especially applicable to improvement in the care of patients. It is made possible through the combined efforts of 154 nurses, educators and specialists, many of whom enjoy national and international prominence and all of whom are filling leadership roles.

The content of the Yearbook is made up of original writings as well as digests, annotated bibliographies and reference lists prepared by the contributors after searching both published and unpublished sources to select from the areas of nursing, education, science, health, hospitals, administration and related fields, the items that serve to indicate professional growth and development for the period. More than 60 areas of nursing interests are identified and brought into this one book as indications of developmental factors influencing the forward march of nursing.

The volume is addressed to the more than 400,000 active nurses whose daily assignments employ their skills in an ever increasing variety of situations, and to the thousands of nurses temporarily inactive who desire a means of keeping informed of the newer methods that follow continuous patterns of growth. Students of nursing at both graduate and undergraduate levels now for the first time will have a clearcut over-all view of the unfolding record of achievement in their profession from year to year.

Pediatrics. Edited by Donald Paterson, M.D., and John Ferguson McCreary, M.D. Pp. 654. Price, $14.00. Philadelphia, J. B. Lippincott Company, 1956.

This truly practical volume, with 36 contributing authors, contains information necessary for the application of modern methods to the care of children. Emphasis is placed upon diagnosis and treatment, and the major portion of the text is devoted to the problems commonly encountered in practice, although mention is made of rarities. The principles of emotional development and the behavior problems of adolescence are discussed. The care of the newborn infant is stressed, and the subject of infant feeding is fully covered. The material on gynecologic problems in children, diarrhea, and gastrointestinal disorders, the section on allergies and the section devoted to neurologic conditions contain the latest information on these important topics. There is coverage, too, of the difficult problem of counseling the parents of an abnormal child. Ocular and orthopedic conditions receive considerable attention as does the treatment of dehydration and electrolyte disturbances. The final unit, Useful Procedures, gives therapeutic diets, drug dosages, immunization table and antibiotic tables.

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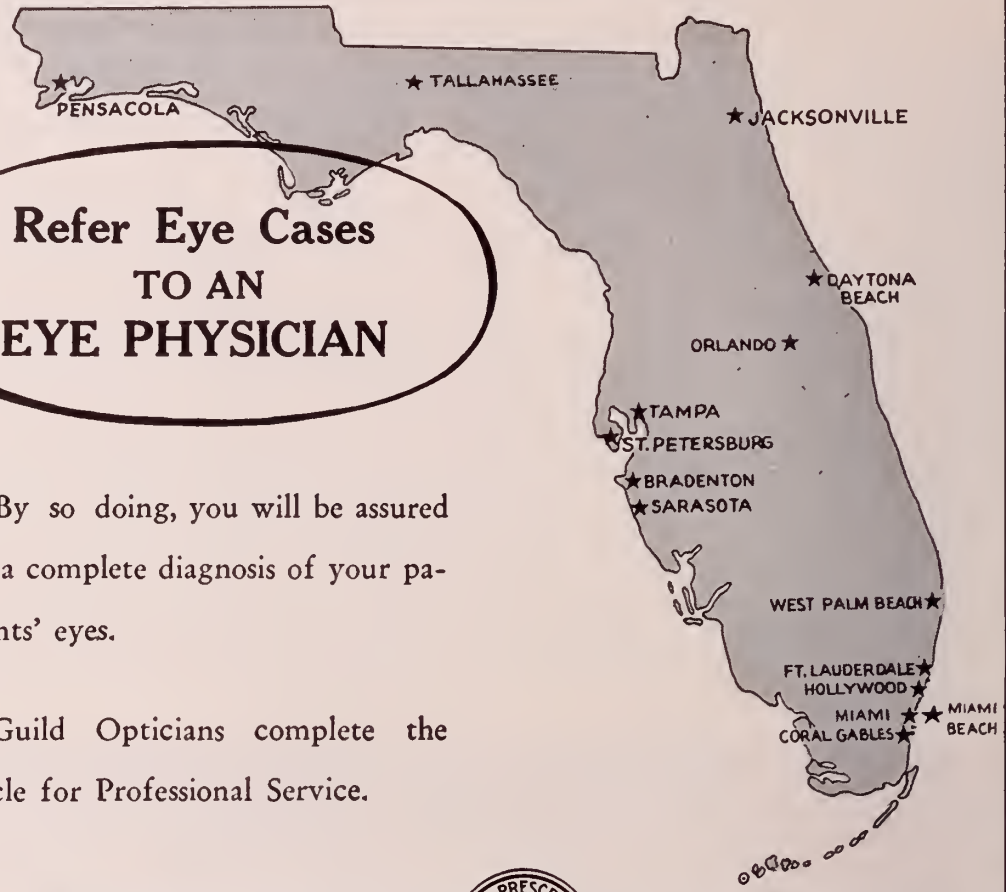

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Dictionary of Dietetics. By Rhoda Ellis, Ph.D. Pp. 152. Price $6.00. New York, Philosophical Library, 1956.

This handy dictionary is a compilation of terms and references related to diet and diet therapy. It is of interest to both lay and professional people who are concerned about diets, nutrition and food as well as dietetics. Particular emphasis has been placed on the practical application of diet with respect to the background, food habits and economic status as well as the physiologic needs of people inside or out of the hospital environment. The terms, in addition to being defined, have descriptive remarks which add to their understanding and application. This is a ready reference book in an ever changing and growing science.

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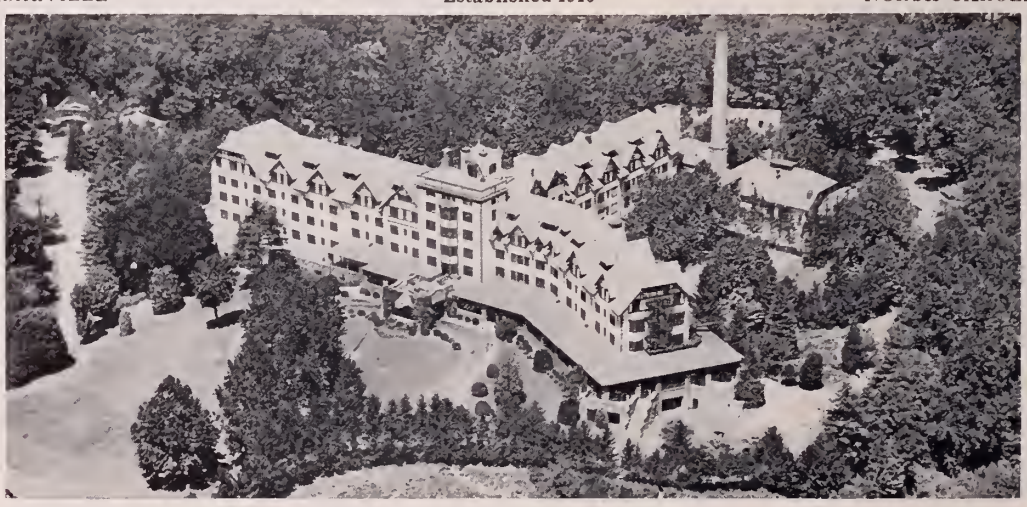

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na Medical Association	Grady O. Segrest, Mobile	Douglas L. Cannon, Montgomery	Mobile, April 18-20, '57
a, Medical Assn. of	Hal M. Davison, Atlanta	David Henry Poer, Atlanta	Savannah, Apr. 28-May 1, '57
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astern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	
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*Ferguson, J. T.: J. Am. Geriatrics Soc. *4*:1080, 1956.

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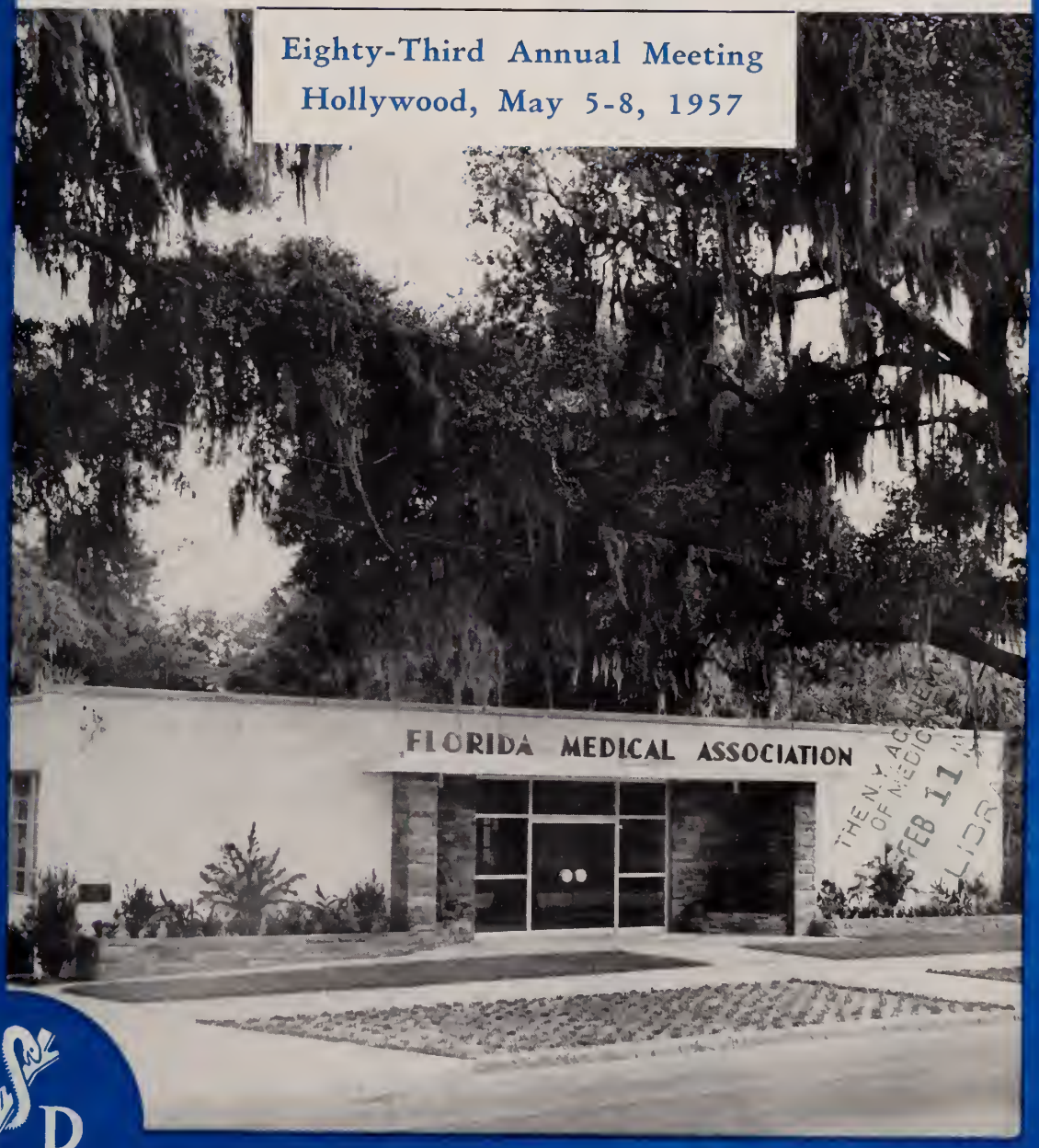

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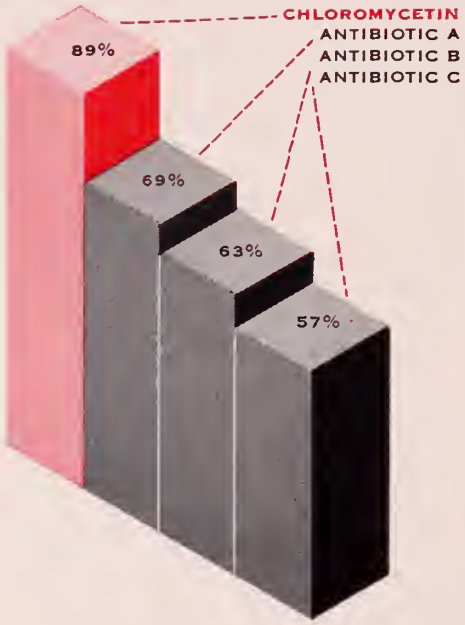

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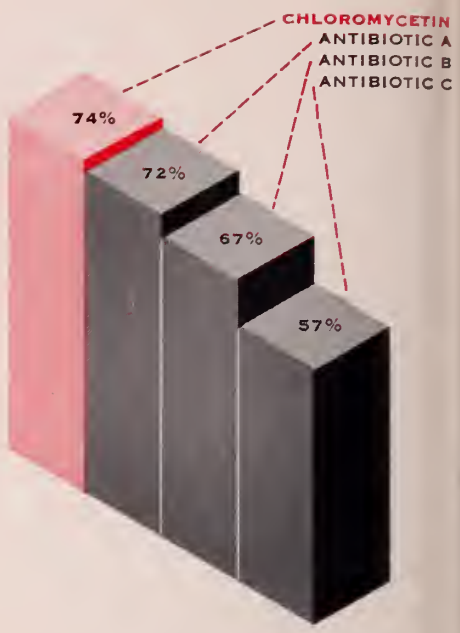

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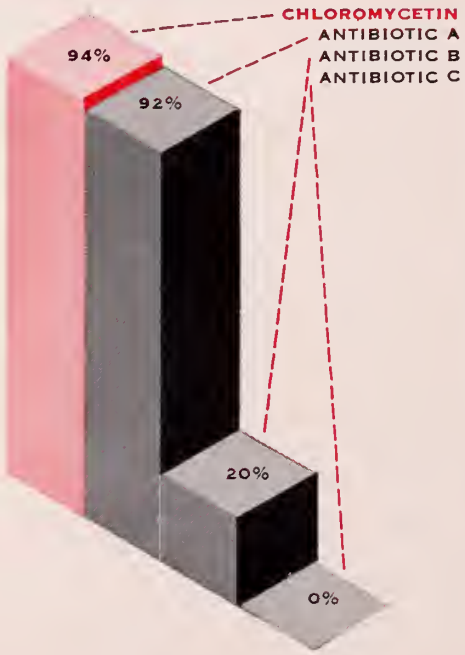

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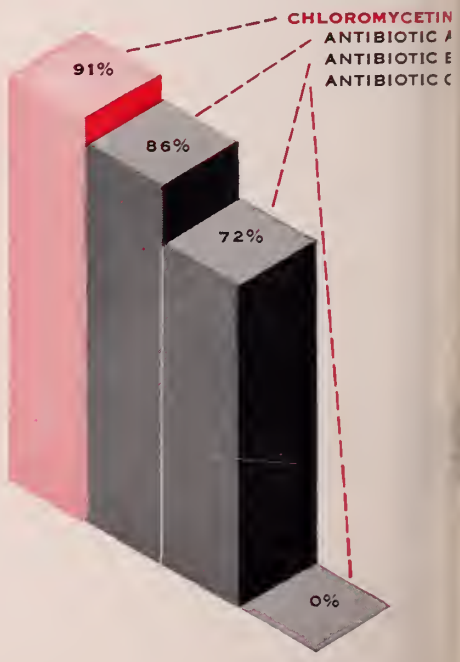

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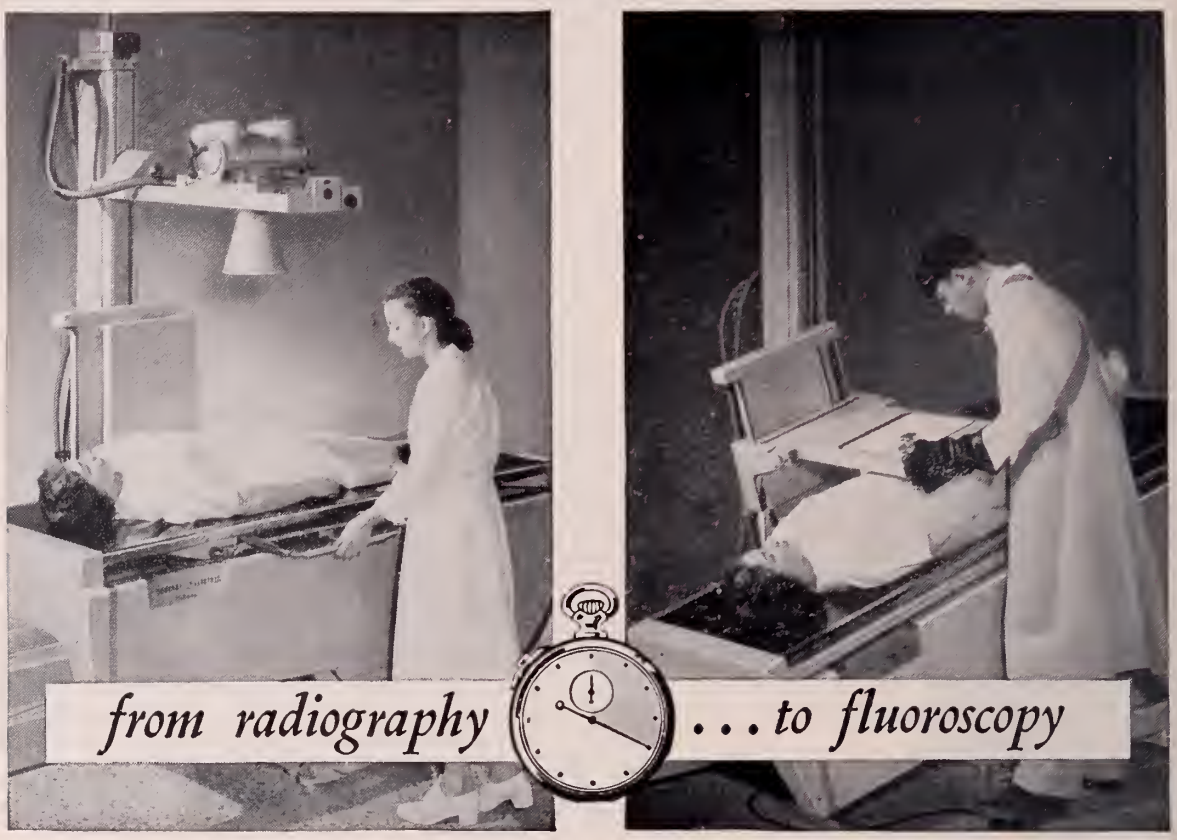

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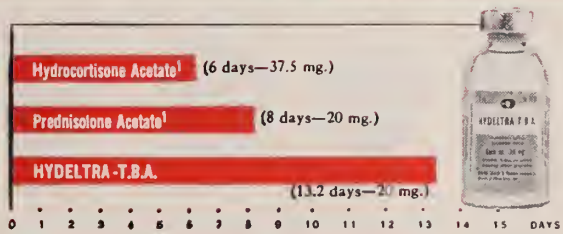

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1. Hollander, J. L., *Paper read at conference in New York City, May 31 and June 1, 1955*

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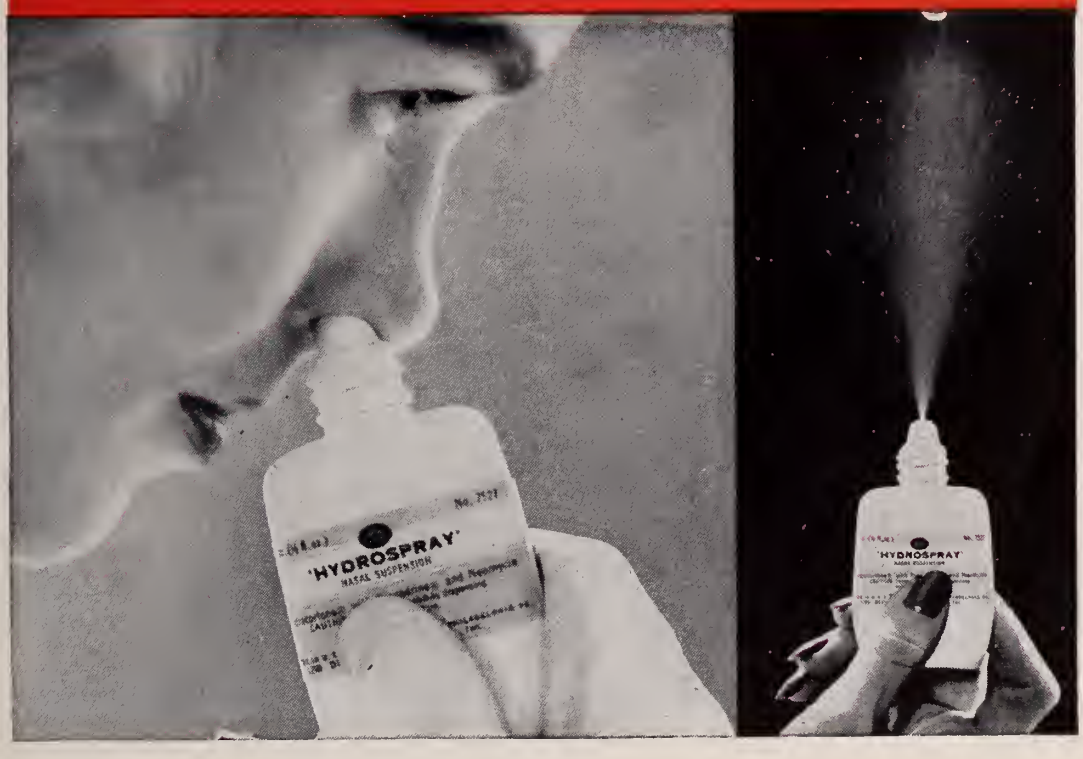

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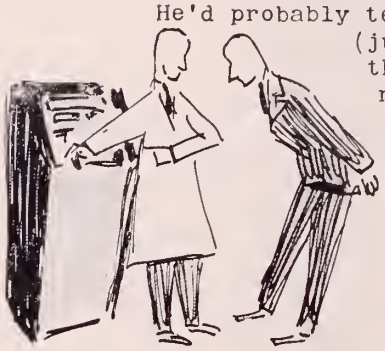

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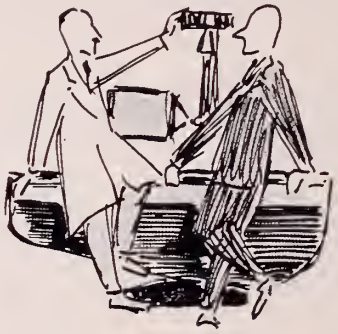

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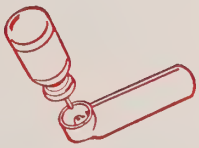

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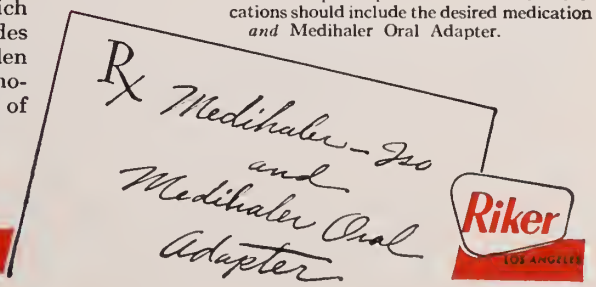

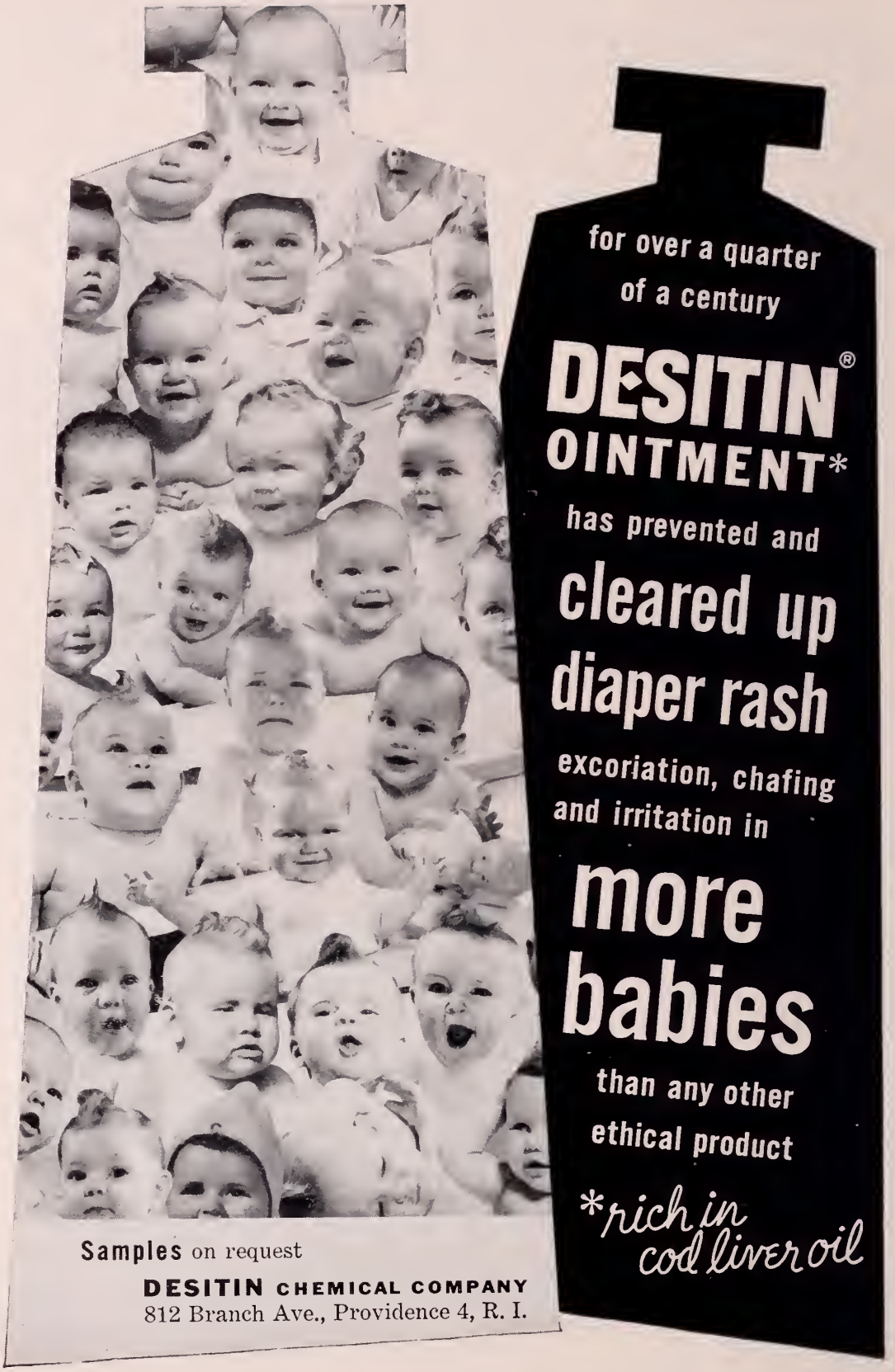
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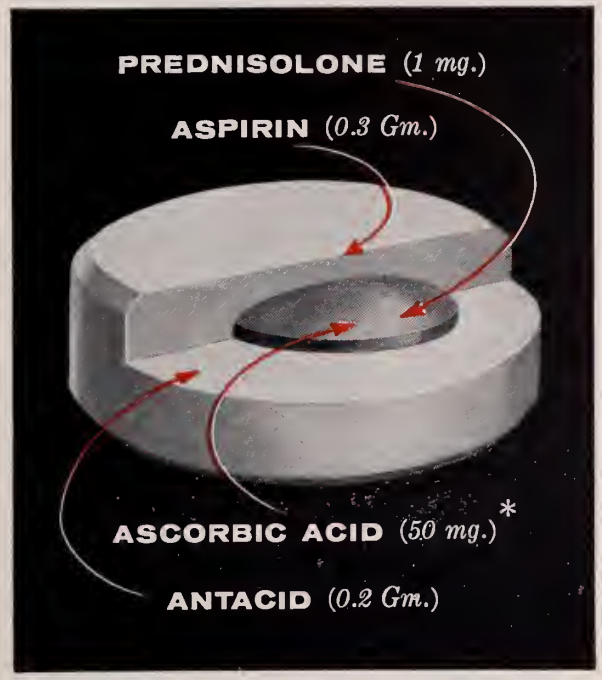

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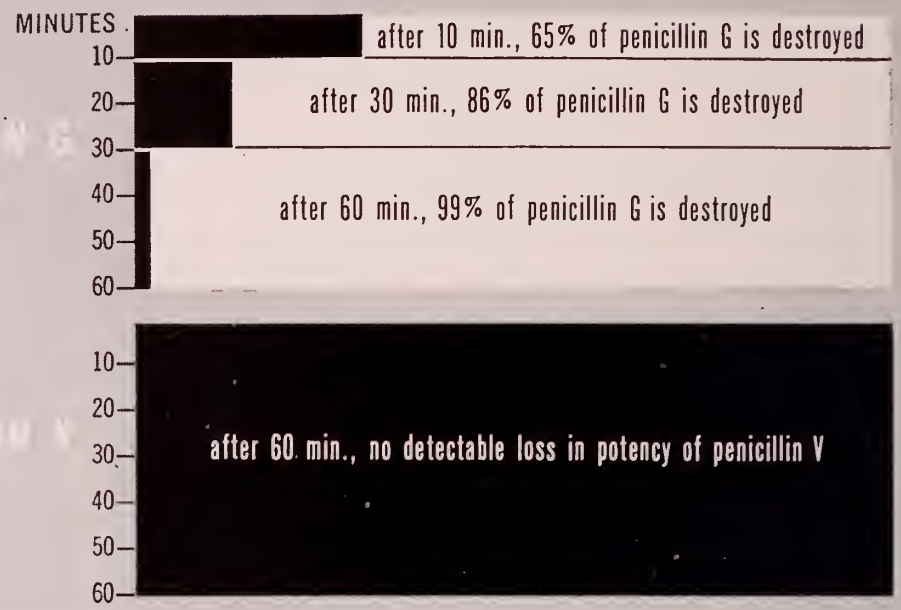

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The Journal of The Florida Medical Association
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A Physiologic Approach to the Problem of Vascular Disease of the Brain

PERITZ SCHEINBERG, M.D.
MIAMI

There is no field in medicine which has produced more spirited controversy than that pertaining to the treatment of vascular disease of the brain. This patent lack of unanimity attests to the poor state of our information concerning the fundamentals of this problem, for even though it is among the commonest of all illnesses, adequate and careful neuropathologic studies are rare and tools for the measurement of cerebral circulation and metabolism have, until recently, been lacking. Therapy has, for the most part, been empiric and without physiologic basis, and all too often results are judged on the basis of too few observations. Since the course of the illness is frequently variable and unpredictable, it has led to erroneous conclusions. The lack of adequate statistical information has also prevented the development of clearcut notions relative to appropriate therapy. Indeed, acute cerebral vascular accidents are designated by different names in various parts of the country, and each term has a connotation which seems to be specific only to that area and which frequently differs amongst individuals. Some of this confusion may eventually be relieved by a scientific form of classification, similar to that now in use for diseases of the heart.

Despite all this, some progress in the understanding of the pathogenesis of these illnesses has been won by the slow accumulation of information obtained by physiologic studies devised to elucidate the mysteries of cerebral circulation and metabolism and by painstaking application of neuropaththologic technics. The purpose of this brief summary is to mention the present state of ideas concerning the treatment of cerebral vascular disease. These notions have been developed by application of information obtained as previously described, and are, therefore, based upon principles as soundly physiologic as the current state of knowledge will permit.

What of the importance of cerebral vascular disease in relation to other major problems that beset physicians? It certainly represents the commonest neurologic syndrome; more than three times as many people (175,000) die annually of cerebral vascular disease as from tuberculosis and diabetes combined. Even more impressive is the datum that 25 per cent of these are in the productive years (25 to 64), and that, in addition, the morbidity from the disease, whether measured in terms of economics or human anguish, is staggering. It is estimated that each of the 1,800,000 stroke victims in the United States each year may require from one to four people to care for him.

Types of Cerebral Vascular Disease

It is a poor commentary on our ability to keep adequate records, both clinical and pathologic, that there are few competent surveys available to indicate the incidence of the various types of cerebral vascular disease. Some average figures indicate that about 20 per cent of all autopsied patients have evidence of vascular disease of the brain. Embolism with infarction accounts for about one third of these; atherosclerosis and multiple infarcts without definite evidence of thrombosis comprise an additional 29 per cent; massive cerebral hemorrhage is present in 15 per cent of all this group, atherosclerosis and thrombosis of a large artery with brain infarction about 12 per cent, ruptured aneurysms and vascular malformations 5 per cent, and hypertensive encephalopathy 4 per cent.

There are many interesting types of cerebral vascular disease which rarely come up for con-

Associate Professor of Neurology and Chief of the Division of Neurology, University of Miami School of Medicine.
Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami Beach, May 14, 1956.

sideration in the differential diagnosis of a neurologic disorder, because they occur infrequently and are therefore infrequently remembered. These include the "inflammatory" vascular disease, which occurs in polyarteritis nodosa or lupus erythematosis, the vascular complications of infections of the meninges or brain parenchyma, and venous thrombosis. Since these phenomena require more specialized consideration, this discussion will be confined to the less esoteric types of vascular disease of the brain, and particularly cerebral hemorrhage, cerebral infarction due to thrombosis or embolism, transient cerebral ischemia, cerebral infarction without definite evidence of thrombosis, and primary subarachnoid hemorrhage from congenital aneurysms or arteriovenous anomalies.

Intracerebral Hemorrhage

Intracerebral hemorrhage is bleeding within the brain substance, with or without rupture into the ventricles or subarachnoid space. This comprises 15 per cent of all cerebral vascular lesions noted at autopsy and is the most disastrous of all forms of cerebral vascular disease, since it results in death in 90 per cent of cases. It occurs in the nuclear masses of the cerebral hemispheres in 70 per cent of the cases, and some extension into the ventricular or subarachnoid spaces occurs in about 90 per cent. If the hemorrhage occurs in the brain stem (usually the pons), the clinical picture is frequently that of decerebrate rigidity, and rapid demise (within 24 to 72 hours) is the rule. Cerebellar hemorrhage likewise produces rapid death. Brain hemorrhage is almost invariably a sequel of hypertension, but may rarely be due to a deep-seated angioma or a bleeding tendency such as leukemia, thrombocytopenic purpura, or hypoprothrombinemia. Its pathogenesis is unknown, though it is now thought that the bleeding is arterial in origin. This concept has never been convincingly proved and is based largely upon the destructive effects of the bleeding. Why hypertensive arteries should rupture spontaneously is not known.

Newer principles in the treatment of cerebral hemorrhage indicate that, occasionally, intracerebral bleeding may produce an expanding clot which requires surgical removal. One looks for focal signs and signs of increasing intracranial pressure before considering the removal of such a clot, which usually lies in the white matter.

Recently there has been a tendency to attempt to lower arterial blood pressure in an effort to prevent additional bleeding. This measure may be useful if the patient is seen early, before irreversible cerebral damage has been done. Several agents have been used for this purpose, particularly Arfonad and hexamethonium, both of which are ganglionic blocking agents. Use of these drugs requires close nursing supervision to titrate the dosage and to keep the mean arterial pressure between 80 and 100 mm. Hg. Reserpine has proved useful when given in large doses (5 mg.) parenterally and it lowers the pressure chronically, requiring less fastidious supervision. The results of this new approach to therapy of this otherwise usually hopeless illness have yet to be evaluated.

When localized cerebral bleeding is suspected, one should avoid repeated spinal taps in order to prevent transtentorial herniation, which is usually fatal. It is not necessary to emphasize the role of really adequate nursing care for patients with such a lesion as well as for all others with cerebral vascular disease. Assiduous treatment of hypertension with the newer hypertensive agents, such as reserpine and Apresoline, may serve to prevent the occurrence of cerebral hemorrhage, and close and thorough care of hypertensive patients is therefore indicated as a prophylactic measure.

Subarachnoid Hemorrhage

Spontaneous subarachnoid hemorrhage is due to a congenital aneurysm or angioma in 95 per cent of instances. It should be remembered that simultaneous bleeding into the substance of the brain and subarachnoid space occurs in the majority of instances of bleeding from an aneurysm or angioma. Since 50 per cent of the patients with this type of lesion die within the first week of illness, it is doubtful that much can be done to reduce the immediate mortality. Those patients who survive the initial week should have bilateral carotid angiography in an effort to localize the aneurysm or aneurysms, since they are frequently multiple. Once surgical treatment has been decided on, the type of procedure must next be considered, and it should be recognized that there are still inadequate statistical data to aid in making that decision. The mortality and morbidity of intracranial trapping of the aneurysm are so great that it should be undertaken only by the most experienced and with the most favorably disposed aneurysms.

The most frequently used surgical procedure is ligation of the common carotid artery. This causes a temporary reduction in intra-arterial

pressure within the aneurysm, which may discourage further bleeding. Further, the redirection of blood flow, with less direct streaming into the aneurysm and dampening of the systolic thrust, may also help to prevent further bleeding. One of the major problems associated with carotid ligation is the morbidity which may result from this procedure, particularly in the middle-aged or elderly. Infarction of a portion of the homolateral cerebral hemisphere with resultant hemiplegia may occur. In a few instances this occurs because of inadequacy of collateral circulation through the circle of Willis, and gradual obliteration of the carotid artery by means of a clamp has been suggested. In other instances, the cerebral infarction follows distal extension of the carotid clot which has been induced by ligation. This pathologic process has been attacked by the use of anticoagulants immediately postoperatively and for the ensuing week to ten days. Evaluation of these procedures must await the final dictum of time.

There is still no universal agreement concerning the methods of choice in treatment of subarachnoid hemorrhage from congenital aneurysms. The available statistics comparing surgical with medical therapy are usually somewhat biased by virtue of the fact that surgical procedures have been conducted primarily in those patients who have survived the first week of illness (during which the greatest mortality occurs) or in patients who were in good clinical condition. There are even a few reports of bleeding from an aneurysm after the appropriate carotid artery has been ligated, and since aneurysms are frequently multiple and bilateral, it is not always an easy matter to decide which one is bleeding. Reduction of systemic arterial pressure by hypotensive agents may accomplish one of the hoped-for results of surgical carotid ligation, without the risks incident to the latter procedure. If the patient survives the first three to four weeks of the illness, there is little evidence to suggest that any type of specific treatment will be of value. These points are brought out only to emphasize the fact that our ideas pertinent to these problems are far from polished and that one must yet keep an open mind concerning therapy in such patients.

Arteriovenous Anomalies

Arteriovenous anomalies usually lie on the convexities of the brain. They are a not uncommon cause of convulsions due to pressure on underlying cerebral tissue and recurrent episodes of leaking. Rarely do patients with such lesions succumb to subarachnoid bleeding. Surgical treatment is by ligation of appropriate entering and leaving vessels, or by block excision. Such procedures are not without morbidity, particularly if the anomaly is on the dominant cerebral hemisphere. The convulsions caused by arteriovenous anomalies can usually be controlled by anticonvulsant therapy.

Cerebral Infarction

Cerebral infarction is the pathologic state which results when the blood supply to an area of brain tissue is not commensurate with the metabolic needs of the tissue. It can occur as a result of thrombosis of a cerebral vessel, by embolism to a cerebral vessel, by a sudden drop in arterial pressure or cardiac output, or by mechanisms as yet unexplained. These last two mechanisms of cerebral infarction have only recently been ascribed their just importance. It is seen following acute myocardial infarctions, after trauma with resultant temporary shock or during partial exsanguination, as in bleeding peptic ulcer. The infarction which follows thrombosis of a cerebral vessel is usually ischemic; that which follows embolism is frequently hemorrhagic and may therefore be confused with spontaneous cerebral hemorrhage.

The physiologic basis for cerebral infarction may be conjectured upon in the light of studies on cerebral blood flow and metabolism, which have revealed that cerebral blood flow falls in almost direct proportion to decrease in the arterial pressure head and to increase in blood viscosity as in polycythemia, and in atherosclerosis and advancing age. As the cerebral blood flow is reduced, intravascular clotting may occur with resulting tissue necrosis, or the oxygen extracting mechanisms of the cerebral cells become strained beyond their capacity with ensuing drop in tissue oxygen consumption and eventually tissue death. It is for these reasons that strokes occur so commonly in the atherosclerotic or elderly population, and are so commonly precipitated by situations which cause a drop in blood pressure or dehydration. It is for these reasons also that we endeavor to maintain an adequate arterial pressure in these patients and keep them well hydrated. Since inactivity predisposes to these abnormal physiologic occurrences, we therefore make an effort to mobilize such patients as rapidly as possible.

The syndromes of gradual occlusion of the basilar or internal carotid arteries have typical

clinical features which permit their early recognition in many instances. Such features also characterize the so-called "slow strokes," in which evidences of cerebral infarction develop slowly and intermittently over a course of several hours to days. It has become increasingly important to recognize these syndromes early, since it now seems likely that early treatment with anticoagulants may actually prevent the occurrence of cerebral infarction in such patients. This therapy will be discussed at greater length later.

Therapy

Our present methods of therapy for cerebral infarction are based upon the hypothesis that it is desirable to increase cerebral blood flow to allow more blood to enter the injured area. Actually, at the risk of seeming nihilistic, one must remember that ischemia is, per se, the best vasodilator, and that the eventual crux of the problem really is to find some means of keeping injured brain tissue alive while collateral circulation develops. This, however, is a task for the future, and the purpose of these notes is to outline and evaluate the technics now being used.

It is well recognized that many cerebral vascular accidents show a transitory clinical picture, with rapid return to normal. The cause for this rapid recovery is not the subsidence of arterial spasm, which seems to be a popular concept, but rather that the neurologic structure whose function is deranged may lie in the periphery of a lesion and normal function returns with loss of edema. In effect, the physiologic or functional defect is at first larger than the morphologic defect. There are, in fact, several mechanisms of recovery from cerebral infarction:

1. Establishment of collateral circulation through the capillaries
2. Establishment of collateral circulation through meningeal arterial loops
3. Redirection of blood through the circle of Willis or pre-Willisian channels
4. Elevation of blood pressure in order to compensate for episodes of hypotension in cases of arteriosclerotic narrowing of main stem arteries.

Of the various methods employed to increase cerebral blood flow and treat cerebral infarction, none have withstood the test of critical scrutiny. Stellate ganglion block, nicotinic acid, aminophylline, oxygen, papaverine and ice pack to the head are without demonstrable benefit. Indeed, of these agents, only papaverine actually does increase cerebral blood flow. Even carbon dioxide inhalation, the most powerful of all cerebral vasodilators, is ineffective in the therapy of cerebral infarction, so far as can be ascertained from available data.

The sad fact is, then, that once an infarct is completely developed, therapy can probably no longer restore the dead tissue, though it is possible that therapy may minimize the size of the infarct and the clinical deficit. It is for this reason that we continue to use 5 per cent carbon dioxide and 95 per cent oxygen inhalations in the treatment of patients with cerebral infarction. Prevention of additional cerebral infarction by early mobilization and adequate hydration is also an important therapeutic motive. A recent approach to therapy has been the concept of prophylaxis in cerebral vascular disease. Many patients with impending cerebral infarction from cerebral vascular thrombosis may have clearcut premonitory signs during the preceding weeks. The intelligent use of anticoagulant therapy has been shown to reduce thromboembolic episodes to less than 5 per cent of their previous frequency. Unfortunately, the anticoagulant therapy must be prolonged and requires a patient physician and faithful patient; but rigidly followed, anticoagulants may not only be life-saving but may also prevent the terrible morbidity of the fully developed cerebral infarct. There is little doubt as to the potential effectiveness of this method of therapy; it is up to interested physicians to find the means of using it.

Rehabilitation

No discussion of treatment of strokes would be complete without the consideration of the rehabilitation of the patient. The importance of an interested and sympathetic attitude toward such a patient cannot be sufficiently emphasized. This is particularly true of the aphasic patient, who is frequently frustrated and discouraged beyond all our comprehension to understand. Rehabilitative care must be begun early to prevent contracture of the Achilles tendon, ankylosis of the joints, and dislocation of the shoulder. The necessary measures are simple and should be a standard part of all proper hospital or home practice. The patient's family should be encouraged to assist in his rehabilitation, and hope for eventual useful functional recovery should always be kept alive. The records of centers where such rehabilitative technics are routinely used have revealed

that startling numbers of stroke victims can be returned to a useful existence. Consideration should be given to the use of anticoagulants for the prevention of additional cerebral vascular lesions.

The seeming reluctance of many physicians to devote a reasonable amount of energy to the therapy of patients with such lesions doubtless stems from the apparent enormity of the task and from our inherent lack of desire to identify ourselves with problems that cannot be "cured." These thoughts are delusions for we actually "cure" few patients in any field of medicine, with the exception of infectious illnesses and certain few surgical procedures; rather, we ameliorate the condition and try to provide comfort for the patient and the ability to lead a useful and satisfying life. Such should be the goal in the therapy of cerebral vascular disease, and intensive effort in this direction offers great hope for the future in this challenging group of diseases.

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Discussion

Dr. Theodore J. C. Von Storch, Miami: It was a privilege to hear this complete summary of a most difficult and obviously extremely important subject. I would like to ask Dr. Scheinberg a question. I would like to know how many patients have strokes because of taxes and how much money the government gets if they do not.

I think I might confine my remarks to a few points I have picked up recently which may be of interest to you and to a few words of warning which all my colleagues cannot agree with nor enjoy. Probably our best treatment is anticoagulant therapy together with the regimen which has been outlined by Dr. Scheinberg. These questions are: What cases do you treat? How long do you treat them? What do you watch out for? These, I think, are the important considerations. First of all, one has to be sure that one is not dealing with a hemorrhage. This requires a lumbar puncture, and it requires that it be properly performed, and that a complete blood cell count be made and not an estimate of red cells by merely looking at the color of the fluid against the available lighting system. If the patient is bleeding, I think that an anticoagulant is apt to make him bleed more, and therefore we must know whether the patient is actively bleeding or not before we use an anticoagulant. There is no way to know this except by lumbar puncture.

The next point is that it has been shown that anticoagulant therapy is most valuable in cases of intermittent thromboembolism, with no bleeding of course, and in syndromes which involve the basilar artery. Basilar artery thrombosis, either intermittent or slowly progressive, is a fatal disorder unless it is stopped by anticoagulants. In order to make that diagnosis, one has to know what a brain stem syndrome is. I suggest that all of us get out our old textbooks and look up what a brain stem syndrome is so that we will be able to classify the patient with this syndrome. Such patients need immediate treatment.

The other situation in which the anticoagulant is of great help is in the intermittent closure or thrombosis of the internal carotid artery. This requires special observation as well, with palpation in the neck, palpation in the pharynx and a knowledge that this syndrome is much more common than has been thought in the past. Many of the so-called middle cerebral strokes are really internal carotid thrombosis. Keeping in mind that these are indications for treatment, I think it behooves us to brush up and find out just how we can recognize these syndromes.

Should we treat the patient with arterial hypertension who has a thrombosis? This question has not yet been settled, and I cannot answer.

Should we treat the patient with hemorrhage? I say no. There are a few who say otherwise.

In the type of case we have discussed, when should we treat the patient? I think if a patient is to be treated with an anticoagulant, he should be treated immediately, as soon as possible. There is information to the effect that most beneficial results do occur when patients are treated very early as well as later.

How long are we going to use prophylactic treatment? Obviously, forever. Otherwise, it is not prophylactic. That, however, is not practical. So, how long are we going to use it? Nobody knows. It is a matter of individual judgment. What happens if we stop the treatment? That is open to question also. There are some who believe there is a rebound phenomenon subsequent to the cessation of anticoagulant therapy, even if it is gradually omitted, and that this rebound is associated with even more thrombosis than has happened before. I know that there are two diametrically opposed schools of thought in regard to this question, which has not yet been settled. I offer only a word of caution.

What about subsequent hemorrhage—hemorrhage elsewhere? If there is a hemorrhage in the intestine or bladder or elsewhere from overenthusiastic therapy, one may have to stop the anticoagulant therapy for the cerebral accident, and that puts one in the embarrassing position of letting a new thrombus form. Also, I would suggest that surgery of course be undertaken with extreme caution in the presence of anticoagulant therapy. Sometimes surgery is performed injudiciously a few days before the anticoagulant therapy has been given, and even two or three days afterward one may see massive cerebral hemorrhages as a result. These then are words of caution. I do not mean to dampen at all our enthusiasm for what I think is really a promising treatment of cerebral vascular accident.

Dr. Vernon T. Grizzard, Jacksonville: I shall confine my remarks to the subject of the treatment of spontaneous subarachnoid hemorrhage, a situation which, as Dr. Scheinberg has said, has a mortality of approximately 50 per cent within the first month. The fundamental problem involved is the age-old controversy of conservative versus radical treatment. What investigative procedures should we carry out, and, of more importance, when should they be carried out, and when should surgery be performed?

Let us spend a moment on the physiology involved after a spontaneous subarachnoid hemorrhage. There is definite impairment of the cerebral circulation. This is due in part to the presence of blood in the subarachnoid space and possibly to the presence of clots within the brain substance itself. I think a more important factor in the impairment of cerebral circulation is the existence of a rather severe degree of vasoconstriction resulting from the irritation of the blood in the subarachnoid space. We might presume that this severe reflex vasoconstriction is an attempt by the organism to offset further bleeding.

When should angiography be carried out? I think it is pretty definitely agreed among neurologists, internists and the majority of neurosurgeons that no procedures other than spinal punctures should be carried out during the first two days. Approximately 50 per cent of those patients who die from the first attack will die within this first two day period. What about the period from two days to the end of the first week? It has been said that during this period angiography will demonstrate lesions in only about one third of the total number of cases of subarachnoid hemorrhage. The mortality rate under conservative therapy drops during this period from 50 per cent to approximately 25 per cent. For investigative and surgical procedures to be practical during this period of time, the mortality rate when angiography and surgery are carried out before the end of the first week would have to be less than the approximately 25 per

cent rate which we find in conservative therapy, and so far there has been no series of cases reported in which the mortality rate for angiography and surgery during the first week has approached this rate for conservative therapy.

What about the period from one to three weeks? During this period angiography will demonstrate lesions in approximately half of these cases. The rise in the rate of positive angiographic findings from one third to one half is thought to be due to a decrease in the degree of vasoconstriction that I mentioned as being present. This vasoconstriction lasts from two to three weeks. Of course the rate of decrease varies with the individual, but its existence for this period of time has actually been demonstrated angiographically by Dr. Arthur Ecker of New York, who has shown on serial angiograms the presence of the vasoconstriction and then the complete absence of such vasoconstriction on angiograms on the same patients performed at some time after the passage of the initial three weeks.

During this same period of time, however, the mortality rate on conservative treatment drops to approximately 10 to 15 per cent from its preceding 25 per cent. In some cases, during this period the condition of the patient is made worse by angiography, but the over-all mortality rate on conservative therapy during the period from one to three weeks is not greatly affected by angiography. In this period, however, surgery still carries a definite mortality which is higher than the rate for conservative treatment. It has been concluded by Dr. Olivecrona of Stockholm, Sweden, who has had a wide experience for many years in surgical treatment of ruptured aneurysms, that it is impractical to attempt active surgical therapy during the first three weeks. It is significant that this time interval of three weeks, arrived at by Dr. Olivecrona from many years of clinical experience, coincides with the period of existence of vasoconstriction, as demonstrated by Dr. Ecker.

I think that it is possible to perform angiography during the period from seven or 10 days to three weeks if the patient is in good general condition, but angiography itself is not an innocuous procedure. It carries a mortality rate itself; it also carries a definite rate of complications, some of which may be temporary, but some of which are unfortunately not temporary. Age, the existence of hypertension, and the initial degree of trauma from the subarachnoid hemorrhage are factors which influence the relative incidence of complications from angiography. The young person who is not hypertensive and who has not had severe neurologic damage from the initial hemorrhage is a much better candidate for angiography during this period of time than the person who is middle-aged or elderly, who does have hypertension and who has had rather severe neurologic damage from the initial episode of hemorrhage.

Complications, however, can occur in even the ideal situation. In my own experience some two or three years ago, there was a young woman, 30 years of age, who did not lose consciousness from the initial subarachnoid hemorrhage, who had no demonstrable neurologic abnormality of any kind and who was not hypertensive. The reaction to the conjunctival test for sensitivity to Diodrast was negative. This patient was given vasodilating drugs, papaverine principally, for two days prior to angiography. Immediately after the second injection of Diodrast during angiography, however, there developed within a period of five to 10 seconds a complete hemiplegia on the right side. Fortunately, during the next 24 hours under intensive vasodilatory therapy with intravenous papaverine, the hemiplegia cleared up, and there were no residuals. A period of 10 days was allowed to elapse, and again the patient was given intensive vasodilatory therapy before angiography. It has been said that lightning never strikes twice in the same place, but in this case it did. During the second injection of Diodrast a complete hemiplegia developed on the left side. Fortunately, this complication cleared up completely, too. This is a graphic demonstration of the fact that in even the ideal situation angiography can be a dangerous procedure. Dr. A. Earl Walker, who presently is a member of the American Board of Neurological Surgery, summed up the present status aptly when he said that it seems probable that the final mortality in subarachnoid hemorrhage will be less if patients are not subjected to angiography or to surgical intervention early.

DR. SCHEINBERG, closing: There were some studies several years ago by Dr. Laurent DeNoe which indicated that central nervous system tissue which has become anoxic survives longer and recovers more completely in an environment in which there is some carbon dioxide available. The reasons for this response are not known because it seems to occur in vitro as well as in vivo. We do know that one of the mechanisms which aid in this recovery in the living human may be the fact that the vessels are dilated. We do know that carbon dioxide therapy has been used for some time in the treatment of certain psychiatric conditions with what is considered to be in many quarters beneficial results. I think the mechanism is not understood.

I should like to have the privilege of making two other brief comments. First, about cerebral arteriography in relation to aneurysms: When you have a neurologist or neurosurgeon see your patient, please be certain that he obtains a bilateral arteriogram. All of us have seen instances in which the aneurysms were bilateral or were multiple. It is important to remember that occasionally even the most competent surgeon may consider ligating the wrong vessel or trapping the wrong aneurysm. It is not always easy to determine which one is bleeding.

Secondly, as regards anticoagulant therapy, I deliberately avoided making any comment about this very important and really completely whole new subject in the therapy of cerebral vascular disease since I knew that Dr. Von Storch is a recent convert to this method and that he would be interested in discussing it. I did have a slide which I neglected discussing and mentioning, but I want to re-emphasize what he has said because I think that by the use of a clue which has been available to us for many years there may be opening a new era, not only in the prevention of cerebral vascular disease but perhaps in its treatment. We do not know how it works. I think it has more to do with the fact that these anticoagulants prevent the clotting of blood. There may be other factors concerning alterations in lipoproteins which are just as important. These brief statistics may be interesting and useful to you. In a series of cases studied by Dr. Irving Wright and Dr. Ellen McDevitt, when they gave the patients anticoagulant therapy, recurrent thromboembolic processes were reduced to less than 5 per cent of their original or preceding frequency. This was a well controlled study. The group at the Mayo Clinic, which has conducted studies in a highly scientific way, has come to the conclusion that this is an invaluable means of preventing further thrombosis in major vessels. It is the obligation of the physician, therefore, to recognize these conditions and begin the therapy early.

Annual Meeting

The Eighty-Third Annual Meeting of the Florida Medical Association is being held May 3-5, 1957 in the Hollywood Beach Hotel at Hollywood.

History of Cobalt

John C. Ajac, M.D.
and
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Coral Gables

Mercy Hospital at Miami has installed a Theratron Unit, using a hectocurie source (over 1100 curies). We are at present accumulating literature from all sources using this modality and will present a review for publication in the next few months.

The element cobalt was discovered and described by Brandt in 1735.[1] The name cobalt is derived from the German word Kobold, meaning goblin. It acquired the name because its ores, being mistaken for those of copper and iron, did not yield the expected metals after smelting. The failure to obtain iron or copper from the likely appearing ores was attributed to the influence or work of a demon or goblin.

Cobalt is a metallic element, similar in many respects to iron and nickel. It is silvery white, weakly magnetic and retains this magnetic property even when brought to a red heat. Some of its descriptive characteristics are as follows: symbol, Co; atomic number, 27; atomic weight, 58.94; valence, 2 and 3; density 8.71 Gm. per cubic centimeter at 21 C.; melting point 1,480 C. and boiling point 3,000 C.

The element seldom occurs by itself in nature. Meteorites frequently contain a high proportion of the pure metal. It is found in the mineral cobaltite in combination with sulfur and arsenic and smaltite, which also contains arsenic, nickel and iron and other ores containing manganese, iron, nickel, sulfur and arsenic. The pure metal is produced by the Goldschmidt process. This method uses the reducing action of aluminum, carbon or hydrogen. For a long time the metal had little or no commercial use or value. The advent of the use of alloys brought cobalt to the fore as an important metal in the production of high speed steels and for the cutting edges and surfaces of hard cutting tools.

The element is chemically active, as is shown by the large series of cobaltous and cobaltic salts and the extremely complex cobalt amines, which are derived from the combination of ammonia and the cobaltic salts. Cobaltous chloride, commonly known as invisible ink, is almost colorless in dilute solution. The writing becomes legible when the paper is heated and the water of crystallization is driven off. Conversely, when the heat is removed and the salt regains a water molecule, it again becomes colorless and the writing disappears. This procedure can be repeated any number of times. Cobalt yellow, green and blue are pigments of high quality.

Historical Background

One cannot resist recounting a bit of the historical background of cobalt. Hobson,[2] one of the authorities on Chinese ceramics, added to the beautiful illustrations in his book a descriptive, detailed word picture of the selected examples of the characteristic ceramics of the Ming Dynasty (1368 to 1644 A.D.). The volume is studded with mention of the pigment "Mohammedan blue," which, when fired, produced that blue so precious to the collector. The quality of the blue color was dependent on the proportion and purity of the cobalt in the cobaltiferous ores of manganese, found either naturally or obtained as the result of patient refinement of the impure ores that were used for ornamentation. The exact source of the pigment is still open to question. It is the same blue as was used by the potters in Persia and the Near East in the ninth century A.D. Burton[3] pointed out that there were deposits of the purest cobalt ore in Baluchistan, India. This statement was confirmed by Hirth and Rockhill, who, in going over the annals of Chinese trade during the Sung Dynasty (960 to 1279 A.D.) mentioned that cobalt blue came from Ghazni near the northwest borders of India.

It is not permissible to continue with this phase of the subject. Should it so happen, however, that interest has been aroused, we assure the reader that the literature on this period is filled with facts that are both exciting and informative.

Advantages of Cobalt

Cobalt is a gray-white metal which, unlike iron, does not tarnish easily. It does not react with body fluids. Animal experiments with the soluble salts show a rapid excretion and only a slight deposition in the tissues. The exact meta-

bolic role is not understood. Distribution of the element is general throughout the tissues, except under experimental conditions in which large quantities are injected. Under these conditions the liver is the chief storage organ, from which 46 per cent of the amount administered was recovered. Solutions of radiocobalt behaved in a similar manner. Within a few days 65 per cent was excreted in the urine and the remaining 35 per cent in the feces. It is evident that small quantities are essential for normal metabolism. The so-called "bush disease" of cattle in parts of Australia and the failure of cattle to prosper in the lush pastures of Florida have been attributed to the absence of cobalt. The addition of this element has permitted Florida to become an important cattle-raising state.

The advantages cobalt has to offer can be divided into two categories, those prior to activation and those following activation. The advantages prior to activation are as follows:

1. There is an adequate, available and inexpensive supply of the metal.

2. This available supply is relatively free of contaminants. It consists of 98.9 per cent metallic cobalt and 1.1 per cent contaminants in the form of iron, nickel and sulfur. None of these produce any radioactive contamination that is detrimental.

3. The metal can be fabricated into any form or shape, either by direct mechanical means or by indirect methods, such as electroplating. The hexagonal crystalline structure of the metal at ordinary temperatures imposes many difficulties in working the metal cold. According to a recent publication, Myers[4] is reported to be preparing needles of pure cobalt.

4. The ability to fabricate the metal into the desired forms and shapes while it is radioinactive eliminates all the industrial hazards associated with handling radioactive materials.

The advantages following activation are, essentially, shown in a comparison of the properties of radiocobalt and radium as agents for external and interstitial gamma radiation therapy. They are as follows:

1. The gamma radiation from radiocobalt is monochromatic, almost homogeneous, and has a mean energy of 1.2 mev.

2. The beta radiation is only 4 per cent of the total energy emission and is of a low energy value of 0.3 mev. A layer of silver plate 0.08 to 0.16 mm. in thickness afforded complete elimination of the beta radiation.

3. There is no opportunity for contamination by gaseous daughter products. Radiocobalt decays into a stable solid element.

4. Radiocobalt from the neutron reactor is available in any desired quantity.

5. The size and weight factor can be diminished by using cobalt of a higher specific activity. This is obtained by means of a special irradiation service, with a resulting activity of 300 to 500 mc/Gm in comparison with the 30 mc/Gm obtained by normal irradiation times.

6. Any radiocobalt that might in any way accidentally enter the body can be rapidly eliminated.

7. It is a source of material with all the aforementioned characteristics at a price range that will not prohibit its use by any qualified individual person or institution.

When compared with radium as a source of gamma radiation, radiocobalt has only one disadvantage, and that is the relatively short half-life of 5.3 years.

It was not until operation of nuclear piles provided a source for large quantities of fairly high specific activity cobalt that progress in research and application became general. As the N.R.X. reactor in Chalk River, Canada had at that time the highest neutron flux available, the possibility of producing cobalt of extremely high specific activity was shown and also the possibility of obtaining a kilocurie source of cobalt 60 in dimensions suitable for use in teletherapy equipment. The first such equipment was designed by and built under the supervision of Dr. H. E. Johns of the University Hospital, University of Saskatchewan, Saskatoon. This unit was completed and installed in the Saskatchewan University Hospital in August 1951.

In addition, the recently developed Theratron Unit or Model B, developed to take advantage of the applicability of cobalt 60 to rotation therapy, was built and the first of these units was installed in the Francis Delafield Hospital, New York City.

Regarding the application of cobalt in tumor therapy, the treatment technics using the teletherapy equipment are similar to the methods used by supervoltage x-ray equipment, Van de Graaff generators, et cetera, with possible minor variations in technic due to increased possibilities of rotation and the multiportal therapy. Cobalt 60 in stainless steel and nylon tubing for interstitial therapy and in various plastic compounds

has been used or suggested as an extension of standard radium interstitial therapy made possible by the availability of isotopes.

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Serum Sickness Type of Reaction To Meprobamate

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Time is perhaps the most important element in determining the side effects of any medication. Frequently this factor is overlooked in publicizing a new preparation. Meprobamate (Miltown, Equanil) has been widely accepted as being relatively free of undesirable effects. The purpose of this paper is to report a serum sickness type of reaction to meprobamate.

Report of Case

A 39 year old white woman was given a prescription for meprobamate in January 1956. She used the drug continuously in doses of 1,200 to 1,600 mg. daily until May 13. During the period of treatment with meprobamate she did not consult a physician and received no other medication. On May 10 she noted itching and a small area of redness on her abdomen. She discontinued the meprobamate on May 13. At that time the skin lesion involved most of the trunk and the proximal portions of all extremities. On the following day she consulted a dermatologist, who told her the rash was probably on the basis of a drug reaction. Because of her complaints of headaches and general malaise, the dermatologist prescribed codeine orally.

I first saw the patient on the evening of May 16 in her home. At that time she complained bitterly of generalized aching of muscles, headache and weakness. Significant features of her history were one episode of rheumatic fever, and allergic reactions to penicillin, mango fruit and salicylates.

On examination, the patient was lethargic and apathetic; her temperature was 103 F. orally. A slightly raised erythematous rash that blanched on pressure covered the entire body excluding the hands, feet, face and scalp. Because of itching, she had applied calamine lotion to the lesions. Other than a grade one systolic murmur in the aortic region, the remainder of the physical examination gave normal results. The patient declined hospitalization and was given 40 units of corticotropin gel intramuscularly. When seen the next morning, she was afebrile, and physical examination was normal except for slight brownish discoloration on the abdomen. The injection of corticotropin gel was repeated, and 20 mg. of hydrocortisone four times a day was prescribed.

On May 20, she complained of a recurrence of the fever, rash, headache and aching muscles. She again declined hospitalization and was instructed to refill the prescription for hydrocortisone. When she was seen on the following day, her temperature was 101 F., and the rash had reappeared. Hospitalization was again advised, and she was admitted to Mercy Hospital that afternoon.

On admission, the physical findings were essentially as previously described. Blood studies revealed a hemoglobin level of 12.2 Gm. per hundred cubic centimeters with a hematocrit reading of 41 per cent and a sedimentation rate of 50 mm. corrected to 48 mm. There were 18,900 white blood cells with a differential count of 85 polymorphonuclear leukocytes, 14 stab forms and 1 lymphocyte. The eosinophil count was 22.2 per cent. Urinalysis gave normal results except for 1 plus acetone. An L. E. cell preparation was reported as being negative. The roentgenogram of the chest was normal. A blood culture was reported as negative. The platelet count was 281,520.

A regimen of 40 units of corticotropin gel intramuscularly every eight hours and a low sodium diet with supplementary potassium chloride was begun. The next morning she was afebrile, and the rash was considerably improved. She still complained, however, of aching muscles and headache. On May 23, because of headache aggravated by movement and sitting, a lumbar puncture was performed. A total protein of 31 mg. per hundred cubic centimeters and 1 lymphocyte per cubic centimeter were reported. The Pandy test gave negative results. The corticotropin was discontinued, and the patient was given 20 mg. of hydrocortisone four times a day. The next morning she had an episode of bronchial asthma that responded promptly to epinephrine. Blood studies now revealed an increasing white blood cell count and elevation of the erythrocyte sedimentation rate. Again there was a preponderance of polymorphonuclear cells on differential smear.

The patient was seen in consultation by an internist, and it was decided to continue hydrocortisone in larger doses. By May 29, she was receiving 40 mg. of hydrocortisone every four hours. That evening she became disturbed and had bouts of uncontrollable crying. The dosage of hydrocortisone was then gradually reduced. On May 30, the white blood cell count was 13,500 with 79 polymorphonuclear leukocytes, 5 stab forms, 15 eosinophils and 1 monocyte. The sedimentation rate was 17 corrected to 14. The patient was subjectively much improved, and there were no abnormal physical findings. She was discharged on June 1. In addition to the corticosteroids she received codeine by injection and chloral hydrate and diphenhydramine hydrochloride (Benadryl) while hospitalized. She was instructed to reduce the dosage of hydrocortisone gradually over the next seven days and to use the Benadryl as needed for sedation.

Summary

A case is reported of a serum sickness type of reaction after the prolonged use of the new tranquilizing preparation, meprobamate. If meprobamate is indicated, its use should be restricted to those who have no history of sensitivity to any other medication.

1394 S. W. Twenty-Second Street.

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Hesperidin-Methylene-Carboxy-Chalcone In Chronic Kidney Diseases

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This paper is intended as a preliminary exploratory survey on the use of a new hesperidin compound in chronic kidney diseases. It represents the joint efforts of 15 Florida physicians.* Many of the patients included in this report are now under treatment with this drug. The results are sufficiently good to warrant presentation at this time so that other groups will be encouraged to undertake similar studies.

The biologic action of Hesperidin-Methylene-Carboxy-Chalcone (HMCC) is not entirely known. Unlike a deficiency of vitamins, which can be corrected, the action of this drug seems to be largely of a pharmacologic nature in that the intake should be at sufficiently frequent intervals to keep some of this material in the body at all times. It does not appear to stay in the body long. The duration of treatment has as yet not been determined. In most instances of kidney disease there is a prompt relapse when the medication is discontinued. From our present studies those patients who were in desperate straits were often benefited most. There was also noted some relief in certain vascular disturbances such as diabetic retinopathy which may occur concurrently with the kidney disease. Improvement in vision and cessation of retinal hemorrhages were noted. Some patients who bruised easily volunteered the statement that blue spots no longer developed.

In this study the only requirement for a patient to be treated with this compound was that a diagnosis of chronic kidney disease be made. Whenever possible the various patients were classified into their respective clinical categories. No patients with acute nephritis were included since many of them recover without treatment. Many of the patients had extensive involvement of the renal cortex. All of them exhibited either albumin or formed elements in the urine, or often both. Several had an increase of nonprotein nitrogen and elevated blood pressure.

*Other clinicians contributing to this study: W. H. Bennett, M.D., Titusville, George Dorman, M.D., Winter Haven, Charles Ykes, M.D., Boynton Beach, Paul Maas, M.D., Pompano Beach, Daniel D. Peschio, M.D., Wilton Manor, Ernest Serrano, M.D., and Robert J. Patterson, M.D., Hollywood, Julius F. Boettner, M.D., Richard V. Mills, M.D., Russell B. Carson, M.D., W. Dodson Wells, M.D., John I. Williams, M.D., Robert S. Faircloth, M.D., and Vincent V. Smith, M.D., of Fort Lauderdale.

The criteria for improvement were objective in that changes in the urinary findings, blood chemistry and blood pressure were used to note improvement.

An arbitrary dose of 100 mg. of the hesperidin compound was established and given four times a day. In two instances this dose was increased to 500 mg. four times a day. One hundred milligrams of ascorbic acid was given with each dose in the early part of this work. Later the ascorbic acid was omitted with no difference in results. The two compounds are supposed to act synergistically.

Throughout the study each clinician was requested to check for any toxic or allergic reactions. To date only one patient exhibited any ill effects and that was a patient who was sensitive to aspirin, which contains an acetic acid group that is also present in our product. It was readily proved that the acetic acid group was the offending agent. Not all types of cases gave the same response. Even patients with the same clinical diagnosis did not respond equally well. It may have been that an increase in dose might have been more effective in the refractory cases. An attempt will be made to individualize the dosage in future studies. In certain instances the symptomatic improvement preceded the demonstrable laboratory changes. Some patients reported a sense of well-being, and one patient said that the foul odor had disappeared from his urine.

In the early stages of this work the supplier ran out of material for a period of time as its early production was in laboratory batches. Two patients were given an insoluble hesperidin preparation that is currently on the market, as an emergency measure, and promptly had relapses. Another patient was given a different water-soluble product and also had a relapse.

This drug has no apparent antibiotic activity, and other agents should be used to control infection when it exists. In a few cases of pyelonephritis, however, there was a reduction in the urinary protein despite the presence of active infection. We do not know whether the compound

acts as a detoxifying agent or enzyme inhibitor, or supplies some essential component in metabolism. There is an improvement in the capillaries, but the mechanism by which it occurs is not known. The drug was given in a case of multiple myeloma, which is not included in this study.* There was a 75 per cent reduction in Bence Jones protein in the urine. This would suggest enzyme inhibition in the tumor cells. In the case in which the foul odor disappeared from the urine, it would suggest a detoxifying agent. Why certain patients often got a sense of well-being before there was any demonstrable objective improvement may also indicate the removal of some toxic agent.

For the means by which the drug stops the loss of albumin through the kidneys we have no adequate explanation. In view of the fact that it reduced the Bence Jones protein in multiple myeloma, one would suspect that it suppressed an enzyme in the tumor and may have been the agent that caused the production of the protein that was lost through the kidneys. We do not know why it should give good clinical results in some cases and poor results in other cases that are similar.

The answer for its modes of action may be given when extensive biochemical investigation is made of its effects on protein and products such as histamine-like substances which may have a toxic action or act as sensitizing agents. Perhaps certain enzymes may be present in quantities sufficiently large to cause destructive action on the capillary vascular apparatus or injure other body tissues, and it may act as an inhibitor to them.

Brief Summary of Case Histories**

Male, aged 60, *Chronic Pyelonephritis* of 16 years' duration. The nonprotein nitrogen dropped from 110 to 53 mg. per hundred cubic centimeters on administration of hesperidin. It rose to 100 mg. on discontinuing the therapy and again dropped to 66 mg. or its resumption. The patient feels generally better when on treatment.

Female, aged 51, *Chronic Pyelonephritis*. There were an occasional granular cast and 1 to 2 white blood cells per high power field at the time of starting medication. One week later white blood cells and casts were rarely seen. The picture remains essentially the same as before starting medication. There were no changes in the blood chemistry.

Female, aged 32, *Chronic Pyelonephritis* of five years' duration. The albumin was 4 plus before HMCC was started and dropped to 1 plus when the patient was given hesperidin. Recurrent attacks of pyelitis are controlled by antibiotics. The albumin remains 4 plus after each attack unless she is given hesperidin; then it drops to a trace or 1 plus. If the hesperidin is discontinued, as has been done on three occasions, there is a prompt recurrence of 4 plus albumin. Numerous formed elements were present at first. They disappeared when this therapy was given. She had a severe relapse when given an insoluble hesperidin preparation. The blood chemistry is normal.

Female, aged 38, *Chronic Pyelonephritis*. The patient gave an allergic response. On questioning, it was learned that she was allergic to aspirin. The medication was discontinued as the acetic acid group was found to be the offender.

Male, aged 86, *Chronic Pyelonephritis,* following prolonged prostatic obstruction. The nonprotein nitrogen dropped from 90 to 45 mg. per hundred cubic centimeters. The formed elements dropped from 140 to 40 per high power field. The patient has received therapy for four months. Three hundred milligrams of HMCC is given four times a day. There is much symptomatic improvement.

Female, aged 56, *Chronic Pyelonephritis*. The albumin was 4 plus and cleared on HMCC therapy. Many formed elements were present and decreased to an occasional formed element as the only finding. This is the first time the urine has been clear in four years despite other therapy. No blood chemistry examination was made.

Female, aged 18, *Recurrent Chronic Pyelonephritis*. The patient was treated with antibiotics and hesperidin concurrently. The albumin cleared along with the infection. The results were not conclusive. The physician should have waited and treated for residual albumin after the infection was cleared.

Female, aged 38, *Chronic Glomerulonephritis*. The patient was a gravida XV at seven months' gestation. The albumin was 1 plus at the beginning of therapy. The urine gave no evidence of albumin for one month on this therapy and then went to 3 plus, remaining there until delivery. No blood chemistry examination was made before or after delivery.

Male, aged 39, *Chronic Glomerulonephritis* of three years' duration. Blood transfusions were given at 10 day intervals. The nonprotein nitrogen dropped from 100 to 48 mg. per hundred cubic centimeters on hesperidin therapy. The albumin remained 4 plus. There was no change in formed elements, which remained at 10 to 15 per high power field. Transfusion were given only at monthly intervals while the patient was receiving the hesperidin. He had a relapse and died when given a different water-soluble hesperidin.

Male, aged 5, *Chronic Glomerulonephritis*. There were 150 to 200 red blood cells per high power field. The albumin was 2 plus. There was no change in formed elements. There was a diminution in albumin when the patient was receiving HMCC. He has relapses with recurrent tonsilitis. No blood chemistry examination was made.

Female, aged 18, *Chronic Glomerulonephritis*. The patient was about seven months pregnant. She had 4 plus urinary albumin, which dropped to a trace in one month on HMCC therapy. She left for another state for delivery, and there was no further follow-up. No blood chemistry studies were made.

Male, aged 55, *Chronic Glomerulonephritis*. The patient had rheumatoid arthritis and a 4 plus albumin with 5 to 9 formed elements per high power field. After he had received hesperidin for two months, the albumin dropped to a trace, and there was an occasional formed element. The blood chemistry was normal.

Male, aged 42, *Chronic Glomerulonephritis*. The albumin was reduced from 4 plus to 1 plus on hesperidin therapy. The patient also had moderate hypertension, which remained the same. There was a recurrence of albuminuria on discontinuing medication. The nonprotein nitrogen was in a high normal range.

Female, aged 54, *Nephrosclerosis*. The patient had had diabetes for 18 years. Urinalysis showed 3 plus albumin, and she had retinopathy. The blood urea nitrogen dropped from 40 to 15 mg. per hundred cubic centimeters and the vision improved at the end of two months. The patient felt generally better.

*Personal communication from Dr. Leroy H. Sloan.

**The summaries of the case histories as presented here are direct abstractions of the histories as presented by the various clinicians. The terms HMCC, which is an abbreviation for Hesperidin-Methylene-Carboxy-Chalcone, and hesperidin are used interchangeably and both refer to the same water-soluble product. Whichever term the clinician used was brought down in the abstract.

Male, aged 70, *Nephrosclerosis.* The nonprotein nitrogen was 65 mg. per hundred cubic centimeters. There was no noticeable change in the nonprotein nitrogen after two weeks. Urinary albumin was 4 plus and went down to 3 plus. No other changes were noted. The patient had a moderate hypertension, which remained unchanged at the end of four weeks of therapy.

Male, aged 68, *Nephrosclerosis.* The patient had hypertension. The blood pressure was 180/110 and went down to 150/104. The blood urea nitrogen was 44 mg. per hundred cubic centimeters and was down to 34 mg. at the end of one month. No change in the urinary picture was noted. He feels about the same.

Female, aged 50, *Nephrosclerosis.* The patient had moderate hypertension. There was some decrease in the blood pressure on hesperidin therapy. There was no albumin in the urine. Some 10 to 15 formed elements per high power field disappeared at the end of one week and did not reappear during the period of observation of one month. The blood chemistry was normal.

Male, aged 70, *Nephrosclerosis and Pyelitis.* The albumin in the urine decreased from 4 plus to none. Only a few formed elements were present. The patient feels generally better. Medication consisted of 200 mg. of HMCC four times a day. All previous therapy had failed.

Female, aged 72, *Chronic Pyelonephritis and Nephrosclerosis.* The nonprotein nitrogen dropped from 48 to 33 mg. per hundred cubic centimeters. The proteinuria remained from a trace to 1 plus. The incontinence disappeared. Nocturia was reduced from six to eight times to once or twice. The patient felt generally better. Previous treatment with antibiotics and sedatives was of no value. The patient received 500 mg. of HMCC four times a day. He discontinued therapy after a month and promptly had a recurrence of nocturia and incontinence, which disappeared again when therapy was resumed.

Female, aged 72, *Nephrosclerosis and Diabetes.* The patient had severe diabetes with symptoms of cardiac failure. The albumin was 3 plus. She died of a coronary attack before follow-up was possible. There was no evidence of aggravation of the coronary disease by hesperidin.

Male, aged 72, *Nephrosclerosis and Diabetes.* The initial nonprotein nitrogen was 94 mg. per hundred cubic centimeters. After four weeks it was 84 mg. The initial albumin was 4 plus. After four weeks it was 2 plus. The initial blood pressure was 160/90 and has not changed.

Male, aged 49, *Nephrosclerosis and Diabetes.* The blood urea nitrogen dropped from 44 to 33 mg. per hundred cubic centimeters. The albumin was 4 plus at the start. After eight weeks it was 2 plus. The blood pressure dropped from 160/90 to 120/80. The patient feels generally better.

Male, aged 67, *Nephrosclerosis and Diabetes.* The patient had severe diabetes with eye and kidney involvement. He also had impaired circulation of the lower extremities. At the end of two months' therapy the blood urea nitrogen dropped from 46 to 33 mg. per hundred cubic centimeters. The urinary albumin decreased from 4 plus to 2 plus. The blood pressure dropped from 160/110 to 140/70.

Male, aged 64, *Nephrosclerosis and Diabetes.* The blood urea nitrogen was 45 mg. per hundred cubic centimeters initially; it went down to 15 mg. after three months therapy. The blood pressure dropped from 190/120 to 150/100. The urinary albumin went down from 4 plus to 2 plus at the end of three months.

Female, aged 34, *Nephrosis.* The edema disappeared on hesperidin. There was no change in the urinary albumin at the end of one week; however, no quantitative study was made. The patient felt generally better. She did not return for follow-up. No blood chemistry study was made.

Female, aged 3, *Nephrosis.* The patient had frequent colds and recurrent attacks of pyelitis with increase of albumin, which persisted after the infection was controlled. She had a gradual decrease in albumin when given hesperidin.

Results

GOOD RESPONSE. — Only one patient with nephrosclerosis failed to show some improvement. The severe chronic pyelonephritis and glomerulonephritis in adults showed improvement in nonprotein nitrogen, urinary albumin or blood pressure, or, in some, all three.

POOR RESPONSE. — Two children, one with chronic glomerulonephritis and the other with nephrosis, had relapses with recurrent respiratory infection.

Three patients with low grade pyelonephritis did not respond to HMCC.

One patient with nephrosclerosis showed little change.

INCONCLUSIVE RESULTS. — One patient who had nephrosis did not return after the second visit. The edema had subsided during the first week. We do not know whether she would have had a residual albuminuria or not after the infection cleared.

One patient with pyelonephritis received both antibiotics and hesperidin concurrently. We do not know how much residual albumin would have remained after the antibiotic therapy.

One patient died of coronary occlusion before the second visit. She had signs of cardiac decompensation on the first visit.

One patient was sensitive to the drug, and it was discontinued after a few days.

SUMMARY.—1. *Chronic and recurrent pyelonephritis.* The patients treated totaled seven. Good response in four; poor response in one; inconclusive results in two.

2. *Glomerulonephritis.* The patients treated totaled six. Good response in five; poor response in one.

3. *Nephrosclerosis.* The patients treated totaled 10, including five with diabetes. Good response in eight; poor response in one; inconclusive result in one.

4. *Nephrosis.* The patients treated totaled three. Poor response in two; inconclusive result in one.

TOTAL. — Of the patients treated 17 were benefited. An additional six gave fair to poor response. Four were not followed up for one reason or another.

Conclusion

Patients with extensive cortical damage of the kidneys generally showed the most improvement.

Patients with minimal damage showed the least improvement. The dosage was arbitrary,

and we suspect it may have been inadequate in some cases.

One patient was sensitive to the drug, and it was discontinued. The sensitivity was proved to be due to the acetic acid group in the drug. There were no digestive disturbances or evidences of protoplasmic poison.

This preparation seems to offer more to patients with chronic renal disease than any other known treatment.

1215 South Broward Boulevard.

Hesperidin-Methylene-Carboxy-Chalcone In Arthritis, Bursitis and Myositis

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This study is a preliminary survey intended to find some of the indications for the use of Hesperidin-Methylene-Carboxy-Chalcone in painful musculoskeletal conditions. In future references this product will be referred to as HMCC.

An arbitrary dose of 500 mg. four times a day was established, given before meals and at bedtime.

Seventy-five patients with pain in joints, muscles and bursae were treated. The response seemed to be in almost direct ratio to the mobility of the diseased part. The joints of the dorsal spine and sacroiliac joints gave the poorest response.

Seven clinicians participated in the study which was made on private patients in their practices. The different clinical entities discussed in this paper are grouped and the results discussed. In each case the clinician was requested to note any unexpected or unusual effects. This is a new drug which has only recently been put on clinical trial. In addition to the results shown by the studies of the various entities, the majority of patients noticed an increased sense of well-being. In two instances purpuric disturbances cleared up. One elderly patient had a severe pyelonephritis with pronounced albuminuria and nocturia. The albumin in the urine dropped to a trace. The nocturia almost disappeared. Both of these recurred along with the arthritis when the medication was temporarily discontinued.

Osteoarthritis of Cervical Spine

Osteoarthritis of the cervical spine was the complaint in three patients in that they had pain and limitation of rotation of the head. In each case there was a decided decrease in pain and an improvement in rotation of the head. One of these patients had an impairment of hearing on one side sufficient to require a hearing aid. After two weeks she no longer needed the hearing aid. Apparently the arthritic process had involved the ossicles of the ear.

Osteoarthritis of Dorsal Spine

In three instances patients had osteoarthritis of the dorsal spine. One of them was reclassified. The other two had partial relief. One is continuing to take the drug.

Osteoarthritis of Lumbar Spine

Osteoarthritis of the lumbar spine occurred in four patients. They gave excellent response to HMCC. One of them had a post-traumatic arthritis and has worn a corset for two years. After receiving HMCC for two weeks, he removed the corset and has not worn it since. Occasionally, he gets a little recurrence of pain and takes a few capsules of HMCC.

Sacroiliac Pain

The chief complaint of six patients was sacroiliac pain. None of them gave a satisfactory response. None had evidence of arthritis elsewhere. We believe that sacroiliac strain was the basis of their pain. Some gave a satisfactory response to corsets. Two were not benefited by any treatment. One of these patients also complained of coccydynia.

Coccydynia

In three patients coccydynia was treated as an arthritic entity although we suspect that it may have been a sprain of the coccygeal ligaments in most of these cases. All of these patients reported a definite injury at some time in the past. Two of them reported improvement.

Osteoarthritis of Upper Extremities in Both Large and Small Joints

Of the six patients treated for osteoarthritis of both the large and small joints of the arms, all except one reported benefit. Most of them also reported an increase in joint mobility. One patient reported a definite increase in mobility, but her hands still hurt some as she used them in her work as an interior decorator. One patient had a slight exacerbation when the HMCC was discontinued.

Osteoarthritis of Lower Extremities

In three patients with arthritis primarily in the lower extremities, the knee was the greatest source of discomfort. The hips and ankles were involved to a lesser degree. Two reported improvement and have continued to improve after a month. The one who did not improve had surgery on her knee. The cartilage was found to be largely destroyed.

Generalized Osteoarthritis

Eight patients were treated for generalized osteoarthritis. One of them had partial relief from cortisone and still further relief from HMCC. His disease was probably of a mixed type. One had generalized mild osteoarthritis. Her pain all disappeared after one week on HMCC and did not recur during the period of observation of one month. Another patient whose deformities suggested a mixed type took several salicylate tablets daily before starting HMCC. He no longer needs salicylates. All of the patients in this group except the one with mild arthritis have continued to take the HMCC either continuously or intermittently according to the amount of discomfort. Some have been on medication for as long as six months with no side or cumulative effects. Three of these patients were elderly and had incapacitating generalized osteoarthritis. In each case there was decided improvement. One of them has returned to work as a skilled laborer. One had his car specially equipped so that he could drive to alleviate the pain. After HMCC medication he now has much less pain and an increased joint mobility. The third patient had to be assisted out of bed and car prior to starting HMCC. She now needs no such assistance and goes about with a cane.

Many of these patients after an initial response continued to improve over a considerable period of time. They noticed improvement not only in lessening of pain but also in an increased range of motion in the affected joints. Here we had the problem of persuading the individual patient to take the drug faithfully once most of the pain was gone. In almost every case in which the medication was continued over a period of time, there was continued improvement. In some of the severe generalized cases continued use of the drug was necessary in order for the patient to remain ambulant.

Rheumatoid Arthritis

There were six patients with rheumatoid arthritis included in this study. Only two gave a satisfactory response. They received 3,000 mg. of HMCC daily. Some of the others will be treated again with larger doses than they received on the initial trial.

There was one case of Marie-Strümpfell arthritis that did not respond to HMCC.

Bursitis

SUBDELTOID BURSITIS.—Of the 17 patients treated for subdeltoid bursitis, in some the disease was chronic with a duration of two years or longer. They all had varying amounts of pain and limitation of motion. The majority of these patients noticed some relief within a few days. Most of them were almost entirely free of pain and tenderness by the end of the second week. They also noticed increased mobility of the arm concurrently with the decrease in pain. Two of these patients had severe acute bursitis. Each responded to therapy. One was given 4,000 mg. of HMCC daily. She was also given salicylate and codeine for the first 36 hours to control the pain. After that time the pain subsided. At the end of a week the shoulder was essentially normal.

In some cases there was residual tenderness because the patient discontinued the medication when the acute symptoms subsided. Those who continued treatment as requested usually experienced a complete disappearance of both pain and tenderness. Three of these patients had a shoulder-hand syndrome. They did exceptionally well considering the stubborn character of this entity. All of them responded rather promptly. One discontinued the HMCC after a few days. He had

a recurrence and was given a cortisone drug along with the HMCC to control it. In those instances in which the bursitis tended to recur after the patient discontinued medication, it was controlled by again taking HMCC, except in the case of the shoulder-hand syndrome mentioned.

Epicondylitis. — Of the three patients who had moderately acute epicondylitis, one was completely relieved in a couple of weeks. One was partially relieved, and one was not benefited. In these patients the disease was more difficult to control because of the trauma inflicted by their daily activities. None of the arms were immobilized.

Trochanteric Bursitis. — One patient had an acute trochanteric bursitis due to trauma of the hip. She made a rapid partial response, but some residual tenderness remained.

Lumbar Myositis

This group comprised 10 women and one orthopedic surgeon who prescribed his own medication. The results were the most gratifying obtained among all the entities treated. Some of these patients had had pain in the lumbar muscles daily for as long as 12 years. In others it was of only a few weeks' duration. Some suffered from a low grade chronic nagging type, while in others the affected area was painful and tender to touch. The results here were uniformly good. By the end of the first week every patient had considerable relief. Some had no pain or tenderness left. By the end of the second week all were completely relieved. In a few patients there was a slight tendency to recurrence. They controlled the pain by taking a few capsules when needed.

Discussion and Conclusions

At the beginning of this study, which is a survey, several types of muscle and joint pain encountered in the practices of the investigators were treated without discrimination in order to find what conditions might be benefited. The results were surprisingly clearcut. The results in bursitis and myositis of the lumbar region of the back were extremely good.

The patients with osteoarthritis on the whole did well. The joints of the more mobile portions of the spine and the extremities responded better than the less mobile joints. Every patient with generalized osteoarthritis had some improvement. In some cases the results were particularly good.

Sacroiliac pain responded poorly. We suspect that most of the patients in this group had pain due to strain rather than to arthritis, and likewise in coccydynia even though the patients reported improvement in most cases.

There were six cases of rheumatoid arthritis. In two of them there was a fairly satisfactory response. The patients received 3,000 mg. of HMCC daily. In a case of Marie-Strümpfell disease there was no response to HMCC.

There was a total of 20 cases of bursitis with only two failures. In one of them extensive calcification of the subdeltoid bursa was present.

Patients with lumbar myositis responded rapidly and completely in every one of the 11 cases regardless of the duration or severity.

This drug now appears to be the one of choice in certain clinical entities. It is often effective in entities in which the cortisone drugs give poorest results. It may be taken over a long period of time with no toxic or cumulative effects. Only one patient during this study was unable to take this drug because of a mild sensitivity. Further uses for this drug will probably be discovered as the clinical trials are extended.

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Medicare

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Control Study on Reserpine in Small Group of Children with Neurologic Disorders

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The mechanism for the clinically recognizable tranquilizing effect of rauwolfia and its derivatives is still unknown. There are reasons to believe, however, that its action occurs in subcortical areas of the brain, probably the hypothalamus from its effects on autonomic activities, for example, and on the brain stem as evidenced by the parkinsonian-like picture developed with overdosage.

Because of these known effects it was decided to test the use of reserpine as an adjuvant in the treatment and management of children with known neurologic disease. From a psychologic point of view such an adjuvant would be useful in the learning situation through a diminution in the intensity of emotional reactions and in the strengthening of ego control. From a neurologic point of view the usefulness could lie in an alteration of cortical — brain stem relationships with beneficial peripheral effects. The concept of such pharmacologic adjuvants is not new,[1,2] and many have been tried.

To test the usefulness of reserpine as an adjuvant, a group of children under observation and treatment at Happiness House in Sarasota was used. Happiness House is a combined school and clinic for handicapped children on an outpatient basis. The group was composed of 29 persons of whom 16 were children. In seven of the group the diagnosis was a spastic condition; in three, postpolio problems; in three, brain injuries; in three, athetosis; in three, ataxia; in three, epilepsy; and in seven, miscellaneous conditions. It was decided to use the patients as their own controls through the use of placebos identical in all respects to the medication. Only one person knew what the child was receiving, and reserpine and placebos were given alternately at two week intervals for a period of two months.

As a preliminary measure all were given a trial on reserpine in an attempt to establish an optimum dosage. On an initial dosage of 0.25 mg. twice a day excessive drowsiness developed in five of the group, in six a flushing of the face, in two swollen eyelids, in four stomach cramps, and in two severe nasal stuffiness. In eight of the patients the dosage had to be reduced to 0.125 mg. twice daily. One child was removed from the group because of symptoms.

Daily records were maintained on the members of the group with ratings by teachers and physical therapists on defined categories. These were coordination, relaxation, strength, alertness, attention, span, social behavior and psychologic reactions.

Results

No accurate correlation could be established between dosage and body weight in terms of the development of side effects.

No correlation could be established between the development of side effects and the type of problem.

Using the two week periods as units, we noted no essential difference between the effect of medication and placebos.

Discussion

In any clinical work with the severely handicapped the problem of controls presents difficulties. The value of placebos was demonstrated in this experiment.

The short intervals that were used were designed to catch any immediate changes brought about by the medication. A research design using more prolonged intervals would be advisable before a completely negative report is warranted.

Conclusion

Reserpine used over short periods did not materially alter the course of treatment for a group of children with spastic, postpolio, brain injury and other neurologic conditions.

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ABSTRACTS

Conservative Surgical Treatment in Massive Gastroduodenal Hemorrhage. By Timothy A. Lamphier, M.D., and William Wickman, M.D. Am. J. Gastroenterology 22:142-151 (Aug.) 1954.

The authors here offer evidence that in the occasional case of massive bleeding from a peptic ulcer, a conservative surgical plan can be utilized to advantage and with a successful outcome. They describe in detail two cases of massive hemorrhage from peptic ulcer. Because of the poor general condition of the patients, conservative surgical therapy was carried out in order to control the bleeding site.

They observe that subtotal gastrectomy with removal of the distal two thirds of the stomach including the pylorus is the ideal procedure for massive hemorrhage of the upper part of the gastrointestinal tract. It is still recommended as a definitive procedure following conservative therapy as soon as the general condition of the patient warrants further operative intervention.

Conservative surgical therapy, they state, should consist of complete excision of the ulcer in the case of a bleeding gastric type. Observing that the ideal conservative management of massive bleeding from a duodenal ulcer is as yet unknown, they advise subtotal gastrectomy if the condition of the patient warrants it. They add that plication of ulcer beds and ligation of adjacent blood vessels are at best poor procedures and are to be avoided if at all possible.

Hazards of the Tin-Can Ash Tray. By Benjamin G. Musser, M.D., H. Clinton Davis, Captain, MC, USA, L. G. Glasson, Captain, MC, USA. U. S. Armed Forces M. J. 5:1679-1682 (Nov.) 1954.

A series of cases is presented in which injury was incurred by soldiers accidentally stepping or jumping on tin cans placed on the floor of the barracks for ash trays. This study shows that meticulous wound closure and adequate immobilization are mandatory in the proper management of severe lacerations on the plantar surface of the foot. Early ambulation is condemned, as painful scars have ensued. These preventable injuries are unique to the military services, and it is suggested that unit commanders can largely eliminate this hazard by providing adequate ash receptacles with blunt or rolled edges.

Hashimoto's Disease in Childhood. By Capt. H. Clinton Davis (MC) and Capt. E. A. Hanske (MC), U. S. Army. A. M. A. Am. J. Dis. Child. 90:173-175 (Aug.) 1955.

Hashimoto's struma, or struma lymphomatosa, is considered to be a disease of the fifth and sixth decades, but it nevertheless can occur over a wide range of age. Standard textbooks rarely refer to the possibility of this disease in childhood, but the authors consider it probable that the incidence in the pediatric age group is higher than generally conceded. They report a case in which the patient was an 11 year old white girl. After commenting upon the nature and management of the disease, they express the opinion that the female sex distribution, the usual incidence during the menopause, and the recently reported several cases at the age of puberty, including their case, lend weight to an endocrine stress theory in the consideration of etiologic factors.

Herpetic Hepatitis of the Newborn. By Sidney L. Arje, Cdr., USN (MC), Carl A. Austin, Lt., USNR (MC), and Alex Sanchez, Lt. Jg., USNR (MC). Obst. & Gynec. 6:169-173 (Aug.) 1955.

A case is reported which should be of particular interest to obstetricians in their efforts to keep abreast of new developments in the search for agents causing death in the newborn. On the basis of the clinical picture and the gross and microscopic postmortem findings, including the finding of the typical inclusion body in the nuclei of involved cells, this case is considered one of a herpes simplex infection in the newborn. Added to those cases already reported in the literature, it would seem to confirm the syndrome, described by Scott, of an overwhelming herpetic infection in newborn infants characterized by hepatitis, pneumonitis, and encephalitis due to the herpes virus. The extensive involvement of the liver has given rise to the term herpetic hepatitis.

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Medicine's Challenge

A few years ago, our profession aroused itself in self-righteous, indignant protest against the surge of socialism toward our ivory towers. In good faith and sincerity, we heartily damned our enemies, expounded our traditional views on individual freedom of enterprise, rallied the support of our patients and retired victorious from the skirmish to sulk and grumble in our tents.

The huge relentless force whose vanguard we defeated has by popular acclaim proceeded to isolate, then inundate us. A few weeks ago we accepted silently the addition of two and one-half million civilians to the paternalistic federal medical program—accepted it without any agonized protest—accepted it with only a short face-saving fuss about fees at the bargain counter—accepted it partly in apathy, but basically because we recognized the present popular supremacy of this phase of national socialism. With this acceptance goes also the realization of the imminent and rapid expansion of the program and all its corollaries.

How will we as physicians meet the challenge implicit in this situation? How well will we, an educated, scholarly, select group, accept and adjust to a society whose principles and philosophy are opposed to our own traditional concepts? How well will we—not a malleable group at any time—be able to subordinate these, our minor and secondary principles and ideals, to our major and fundamental concepts of humanitarianism and selfless dedication to universal service? And how well then shall we regain and retain our traditional and honorary niche above all other groups as dedicated idealists in whom the love of knowledge and service transcends all materialism? Can we accomplish this objective in a changing inimical society and will we do so? Can we and will we recapture the stature, the dignity and the integrity that is our heritage through the ages? Will a scholar-philosopher in years to come still be able to say with Stevenson, "There are men and classes of men that stand above the common herd. The soldier, the sailor, the shepherd not infrequently, the artist rarely, rarelier still the clergyman, the physician almost as a rule." We wonder. . . .

Medicare Program

On Dec. 7, 1956, the Department of Defense and the Department of Health, Education, and Welfare launched an extensive federally sponsored medical care program, authorizd by an Act (Public Law 569) of the Eighty-Fourth Congress. Known as Medicare—Military Dependent Medical Care—this unique program is one of first magnitude in the field of health care coverage. It provides benefits to dependents of all branches of the armed services and to all "uniformed" service families as well—the United States Public Health Service, the Coast and Geodetic Survey, and the Coast Guard.

By this mechanism dependents of members of these services, after receiving proper identification from military commanders in the area, are at liberty to seek medical, surgical or hospital care to which they are entitled from military facilities or from private physicians and private hospitals. Dependents of military personnel stationed in other areas also may seek either private or military care. To families residing at military installations the Department of Defense may make available military facility care only, but it is expected that this policy will not be closely followed at the outset, thus giving all eligible military dependents the choice of military or civilian care. It is estimated that there are 2,000,000 military dependents at the present time, 40 per cent of whom, or 800,000, would be eligible for civilian care.

Spouses and children of active duty personnel are entitled to medical and hospital care from private sources. Benefits obtainable through a civilian physician and hospital are limited to: "acute medical conditions, including acute phases of chronic diseases; surgical conditions; contagious diseases while in hospital; complete obstetrical and maternity care; 365 days' hospitalization (semi-private accommodations) for each admission, including all necessary services and supplies by hospital; pre- and post-hospitalization services of doctor for bodily injury or surgical operation, including certain tests; acute emergencies of any nature if threat to life, health or well-being, including temporary treatment of acute emotional disorders; diagnostic tests and procedures during hospitalization."

Under this law, the medical care was worked out on a regional or statewide basis. Many state medical associations, including the Florida Medical Association, agreed to act as the contracting agent with the federal government to render the medical care through their physician members. These societies were free to choose a fiscal agent—a medical care insurance company—to receive government funds and make the individual payments to the individual physicians for the care they render. Almost universally they chose Blue Shield Plans to provide the administrative machinery for Medicare.

The key to the problem in each state was the preparation of a suitable fee schedule which would be acceptable to the individual physician who participates in the program. Under the program a physician who accepts the patient for treatment would agree to render the specific medical care and to accept the fee schedule as payment in full for the medical care rendered. The law, however, recognizes the right of the physician to decline to accept cases for medical treatment. The patient, too, is assured of complete freedom of choice to select any physician who agrees to render the medical care for the formal fee schedule.

Because of the importance of the new law, the many problems it poses for the medical profession and the stake every member of the Association has in the Medicare program, every effort has been made to acquaint the members with the details of this federal health program through various communications and through explanations by officials at the national, state and county levels. At the District Meetings, held late in October and early in November, Dr. John D. Milton, of Miami, immediate past president of the Association, explained the law. A proposed fee schedule, prepared for the Association by a committee consisting of Dr. Milton, chairman, Dr. Jere W. Annis, of Lakeland, and Dr. S. Carnes Harvard, of Brooksville, at the request of the American Medical Association and the Department of Defense, was also explained. It was based on the California Relative Value Schedule and couched in the nomenclature supplied by the Department of Defense. In this schedule, medical and surgical procedures are assigned a relative value, which is determined by evaluating their comparative worth in terms of units.

On November 4, a special meeting of the House of Delegates was held at the Hotel Roosevelt in Jacksonville to consider and act upon a

proposed plan for implementing the new law, including a fee schedule, in Florida. The minutes of that meeting are published in this issue of The Journal.

At the direction of the Department of the Army, which acted as executive agent for the Department of Defense, the Association's representatives, Dr Milton and Mr. Ernest R. Gibson, Managing Director, accompanied by legal counsel, Mr. Harry T. Gray, of Jacksonville, reported to the Office of the Surgeon General of the Army in Washington on November 5. Representing Blue Shield at this meeting were Dr. Russell B. Carson, President, Mr. H. A. Schroder, Executive Director, and Mr. H. Plant Osborne, Attorney. Mr. Bernard Hirsch of the A.M.A. Law Department was also present. Acting under authority from the House of Delegates, Dr. Milton entered into a contract for the Association with the federal government which includes a negotiated Schedule of Allowances (Fee Schedule) within the limits set by the House.

Blue Shield of Florida then agreed to serve as fiscal agent in implementing this program and became a party to the tripartite contract, which was signed on December 10. For this service to physicians and the public Blue Shield will be reimbursed by the government for actual costs only; it serves strictly in an administrative capacity.

A Schedule of Allowances and complete details of the Medicare program were sent as soon as possible to every member of the Association. It remains for all members to familiarize themselves with all aspects of this program, already in effect for two months and now getting well under way, and to cooperate to the fullest extent in implementing it by providing eligible dependents with the medical care to which they are entitled by law.

President Langley has appointed a committee to study the Schedule of Allowances and make recommendations to be used as a basis for renegotiation at the termination of the present contract on June 30, 1957. The members of this committee were chosen to represent the five major categories of Surgery, Medicine, Radiology, Pathology and General Practice with three members each, as directed by the House of Delegates. Geographic considerations also were adhered to, and appointments were made on a rotating basis. The members of this committee are: District A: Drs. George W. Morse, Pensacola, Surgery; James T. Cook Jr., Marianna, General Practice; and Gretchen V. Squires, Pensacola, Pathology; District B: Drs. Thomas R. Collins, Orlando, Medicine; W. Ansell Derrick, Orlando, Pathology; C. Robert DeArmas, Daytona Beach, Radiology; and Leo M. Wachtel Jr., Jacksonville, General Practice; District C: Drs. John P. Ferrell, St. Petersburg, Radiology; H. Phillip Hampton, Tampa, Medicine; James N. Patterson, Tampa, Pathology; and Paul F. Wallace, St. Petersburg, Surgery; and District D: Drs. John V. Handwerker Jr., Miami, General Practice; Frederick K. Herpel, West Palm Beach, Radiology; Reuben B. Chrisman Jr., Coral Gables; Surgery; and Donald F. Marion, Miami, Medicine. Dr. Marion will serve as chairman of this committee.

An additional committee, to be headed by Dr. Milton, is in process of formation to serve as a mediation committee. This committee will hear protests from physicians and deal with new situations which may arise that are not specifically covered in the present agreement.

President Eisenhower approved regulations to put the Medicare program into effect "with great satisfaction." He said that he had been "personally interested in this important program since its inception" and noted that it would provide for at least 40 per cent of service families who previously were unable to receive adequate medical care from the government. After the law was passed, the American Medical Association urged all medical associations to cooperate with the Department of Defense in carrying out the program and directed its Board of Trustees "to initiate direct liaison with the Department of Defense and render all reasonable and effective aid and assistance to state and county medical societies toward implementation of the Act." A special Task Force on Dependent Medical Care was then established.

The support and participation of all members of the Florida Medical Association is essential if this broad plan is to succeed. Physicians are on notice that the government can withdraw this program at any time it desires to do so or finds that the quality of service falls below acceptable standards. Many officials of the government would prefer to confine all this care to military establishments alone. During this trial period of the Medicare program, therefore, private physicians have the responsibility of providing the finest medical service possible to this group of military dependents as a trust, an obligation to the entire profession. It is incumbent upon them to discharge this trust in exemplary fashion.

Program
Eighty-Third Annual Meeting
Florida Medical Association

The program for the Eighty-Third Annual Meeting at the Hollywood Beach Hotel, May 5-8, 1957, has been arranged to permit better organization of the Association's work. The program will permit members who find it impossible to attend the full session to come for one day, Tuesday, and attend the major scientific activities. The work of the House of Delegates has been spread so that adequate hearings of reference committees may be held without interference from other activities.

Saturday and Sunday, as in the past, have been devoted primarily to activities of the Specialty Groups. The first session of the House of Delegates will convene in midafternoon Sunday. Monday will begin with the General Session and continue with working sessions of Committees and Blue Shield. Luncheon and dinner are devoted to alumni, fraternity and specialty group meetings. Tuesday is devoted to two scientific sessions and is climaxed with the major social activity of the meeting. The second session of the House of Delegates on Wednesday will conclude the meeting.

The Scientific Exhibit will contain many interesting presentations. In addition to demonstrations of new technics, several unusual exhibits have been arranged. A model of an artificial heart-lung apparatus will be demonstrated, and the comparative anatomy of animal skulls as they relate to the sense of human smell will be shown.

A program of outstanding motion pictures and kinescopes has been arranged for Monday evening. At the time The Journal goes to press, negotiations are still in progress for participation Monday afternoon in a nation-wide closed-circuit television hook-up with two other state societies.

The program allows adequate time for relaxation. The hotel is planning the use of its excellent facilities to the fullest to make this an outstanding meeting.

American College of Surgeons
Fracture Course
Chicago, April 10-13

An intensive course on fractures and other trauma will be offered to all interested members of the medical profession by the Chicago Regional Committee on Trauma of the American College of Surgeons. The course will be held for three and one-half days, from April 10 to 13, 1957, at the John B. Murphy Auditorium, 50 E. Erie St., Chicago.

Lectures and demonstrations will be conducted by distinguished surgeon-teachers of the Chicago area, all recognized as authorities in their fields. Clinical cases will be presented, and discussion and questions from the floor are invited. Subjects to be covered include bony trauma, soft tissue trauma, vascular injuries, bone grafting, traction technic, industrial casualties, farm injuries, auto crash injuries, burns, amputations, head injuries and others.

The course is being given under the direction of Dr. Sam Banks.

First Pan American Cancer
Cytology Congress
Miami Beach, April 25-29, 1957

The Department of State of the United States Government has transmitted through its official channels to the Ministries of Health of 21 nations of the Western Hemisphere invitations on behalf of the Organizing Committee to send representatives to the First Pan American Cancer Cytology Congress to be held in Miami Beach, April 25-29, 1957. It is expected that the Congress will attract approximately 1,000 physicians, scientists and public health authorities from the Americas.

An invitation is extended to all physicians interested in cancer diagnosis and research to attend this international meeting. Medical and scientific leaders will present a program combining latest advances in cancer detection by cytologic methods, radioisotopes, genetics, microbiology, electron microscopy, the biology of cancer, and research in leukemia. Outstanding sectional chairmen include: Clinical Cytology, William Bickers, Richmond, Va., Jose Mezzadra, Buenos Aires, Argentina, and Arnaldo de Moraes, Rio de Janeiro, Brazil; Electron Microscopy, Keith Porter, Rockefeller Institute, New York City; Genetics, Leonell Strong, Roswell Park Institute, Buffalo, N. Y.; Immunology, Reuben L. Kahn, University Hospital, Ann Arbor, Mich.; Leukemias, Howard Bierman, City of Hope, Los Angeles, Calif.; Microbiology, F. Duran-Reynals, Yale University School of Medicine, New Haven, Conn.; Nucleolus, M. J. Kopac, New York University, New York City; Particulate Chemistry of Cancer Cells, W. C. Schneider, National Cancer Institute, Bethesda, Md.; Radioactive Isotopes, Paul C. Aebersold, Chief, Isotopes Division, Atomic Energy Commission, Oak Ridge, Tenn.; Response of Cancer Cells to Antibiotics and Viruses, Alice E. Moore, Sloan-Kettering

Institute, New York City; Tissue Culture, George O. Gey, Johns Hopkins University School of Medicine, Baltimore, Md., and Tumor Transplantation, Harry N. Greene, Yale University School of Medicine, New Haven, Conn.

Special emphasis will be placed upon gynecologic cancer and the revolutionary role of cervical cytology as a screening test for uterine cancer, recently perfected for population screening. The role of cytodiagnosis in improving surgical treatment in lung cancer, prostatic and gastrointestinal cancer will be discussed. Latest concepts and recent advances in basic cancer research will be surveyed by authorities from countries of North and South America.

Two awards of $1,000 each will be presented at the conclusion of the Congress. These awards, called the Wien Award, will be made to the two scientists presenting papers whose work is judged to represent "outstanding research in cancer cytology." Established in 1953 by Leonard Wien, well-known philanthropist and former president of the Cancer Institute at Miami, the Award consists of a plaque suitably inscribed and $1,000 given to recognize and encourage further research in cancer cytology. The work is judged by a Research Committee headed by Dr. E. V. Cowdry of St. Louis as representing the most significant research in cytology during that year. Awards for 1956 and 1957 are to be made at the Congress. Previous recipients of this Award include Dr. George N. Papanicolaou of Cornell University Medical College, New York City; Miami Cancer Institute Director, Dr. J. Ernest Ayre; and Dr. Ruth Graham of Vincent Memorial Hospital, Boston.

Dr. Wayne Rogers, P.O. Box 633, Coral Gables, is the program chairman. The scientific exhibits chairman is Dr. Homer L. Pearson, P.O. Box 633, Coral Gables.

Of special interest to practitioners of medicine will be explanations of procedural details and methodology for the application of cytodiagnosis for early detection of cancer in the physicians' office. Recently perfected methods and technics emphasize the importance of the family physician as the key figure in cancer control programs. The keynote of the Congress will be Cancer Protection Through Early Detection.

The program of the Eighty-Third Annual Convention of the Florida Medical Association is scheduled to be published in the April issue of The Journal.

Graduate Medical Education Cardiology Seminar February 21-23

The Seminar on Cardiovascular Diseases, to be presented by the Northeast Florida District Heart Association in cooperation with the Florida Medical Association, the Florida State Board of Health, and the Division of Postgraduate Education of the College of Medicine of the University of Florida, will be held at the auditorium of the Duval Medical Center in Jacksonville on February 21, 22 and 23, 1957. The program, which has been mailed to all physicians in the state, includes two panel discussions and lectures by Dr. Charles Anthony Hufnagel, Professor of Surgical Research and Associate Professor of Surgery, Georgetown University Medical School, Washington, D. C., and Dr. Paul Maurice Zoll, Assistant Professor of Medicine, Harvard Medical School, Boston.

Topics to be discussed by Dr. Hufnagel are: Aortic Stenosis, Arterial Occlusive Disease, Aneurysms of the Aorta, Interatrial Septal Defects and Experiences with Artificial Cardiopulmonary Machines. Dr. Zoll will present the following subjects during the two and a half day program: Coronary Heart Disease, Clinicopathologic Correlations, Interarterial Coronary Anastomoses and Surgery for Coronary Disease, External Electric Stimulation and Defibrillation of the Heart, Treatment of Stokes-Adams Disease and Program for Unexpected Cardiac Arrest in the Operating Room.

STATE BOARD OF HEALTH

Rheumatic Fever Case Registry

Florida represents a haven to which persons with rheumatic fever or rheumatic heart disease often migrate in the belief that its climate offers them a better prognosis. If the experience of Florida physicians were documented, it could provide valuable information concerning these conditions. Furthermore, rheumatic fever is not uncommon among persons resident in Florida, although the frequency of occurrence of the condition appears to vary widely in different parts of the state. The State Board of Health in cooperation with the Florida Heart Association and the National Children's Cardiac Hospital has established a case register for the collection of information about rheumatic fever and rheumatic heart disease through practicing physicians, general hospitals and other facilities providing medical services. Analysis of

such data will provide physicians with reasonably accurate information concerning the natural history of rheumatic fever and rheumatic heart disease in Florida which could be of practical value. Rheumatic fever has been declared a notifiable disease by the State Board of Health. Cases may be reported on the same card employed for reporting all other notifiable diseases.

Physicians are offered an unparalleled opportunity once more to apply the principles of preventive medicine to the eradication of a specific disease, rheumatic heart disease, by preventing rheumatic fever.

In order to be able to collect a reasonable picture of the incidence of rheumatic fever in Florida, each physician is urged to report cases when the patient first seeks treatment. Control measures depend entirely on how well individual cases are reported by the practitioner, and every physician should give his full support to the operation of a rheumatic fever case registry by reporting his cases.

House of Delegates

Proceedings of Called Meeting

Roosevelt Hotel, Jacksonville, November 4, 1956

A called meeting of the House of Delegates of the Florida Medical Association convened in the Floridan Room of the Roosevelt Hotel, Jacksonville, at 10:30 a.m. on Sunday, November 4, 1956, with President Francis H. Langley presiding.

Dr. Ralph W. Jack, Chairman of the Credentials Committee, announced that a quorum was present, 79 delegates being registered. (Subsequent report of the Credentials Committee showed 83 delegates registered.)

Delegates

ALACHUA—Henry J. Babers Jr., F. Emory Bell, John E. Maines Jr.
BAY—William C. Roberts
BREVARD—Theodore J. Kaminski, Laurent L. LaRoche
BROWARD—Julius F. Boettner, Russell B. Carson, Burns A. Dobbins Jr., John H. Mickley, (*Absent—Donald H. Gahagen, Richard A. Mills*)
COLUMBIA—(*Absent—Laurie J. Arnold Jr.*)
DADE—Jack Q. Cleveland, Vincent P. Corso, James J. Hutson, Ralph W. Jack, Frazier J. Payton, Hunter B. Rogers, Walter W. Sackett Jr., Oliver P. Winslow Jr. (*Absent—Edward R. Annis, Harry E. Beller, Turner E. Cato, Reuben B. Chrisman Jr., Francis N. Cooke, Edward W. Cullipher, Robert F. Dickey, L. Washington Dowlen, Franklin J. Evans, Richard M. Fleming, George Gittelson, J. Raymond Graves, Maurice M. Greenfield, R. Spencer Howell, Walter C. Jones, David Kirsh, Alfred G. Levin, Donald F. Marion, Frederick P. Poppe, Warren W. Quillian, T. D. Sandberg, Ralph S. Sappenfield, Oden A. Schaeffer, Donald W. Smith, Joseph S. Stewart, William M. Straight, Corren P. Youmans*)
DUVAL—James L. Borland, Frederick H. Bowen, Hugh A. Carithers, A. Judson Graves, Karl B. Hanson, Gordon H. Ira, F. Gordon King, Raymond H. King, Joseph J. Lowenthal, Charles F. McCrory, Sidney Stillman, Leo M. Wachtel Jr. (*Absent—J. K. David Jr., Arthur L. Hardie Jr., Kenneth A. Morris*)
ESCAMBIA—Herbert L. Bryans, Alpheus T. Kennedy, George W. Morse, Walter C. Payne Sr., Gretchen V. Squires
FRANKLIN-GULF—Joseph P. Hendrix
HILLSBOROUGH—H. Phillip Hampton, Wade C. Myers Jr., James N. Patterson, Madison R. Pope, Edward F. Shaver (*Absent—Eugene B. Maxwell, David R. Murphey Jr., Julien C. Pate Jr., William M. Rowlett, Robert W. Withers*)
INDIAN RIVER—(*Absent—William L. Fitts 3rd*)
JACKSON-CALHOUN—James T. Cook Jr.
LAKE—(*Absent—Sanford C. Colley*)
LEE - CHARLOTTE - COLLIER - HENDRY—(*Absent—Earl S. Davis, William H. Grace*)
LEON - GADSDEN - LIBERTY - WAKULLA - JEFFERSON—Francs T. Holland, Robert H. Mickler (*Absent—George H. Massey*)
MANATEE—(*Absent—Millard P. Quillian*)
MARION—Henry L. Harrell
MONROE—Ralph Herz
NASSAU—(*Absent—Benjamin F. Dickens*)
ORANGE—Frank C. Bone, Chas. J. Collins, Carl S. McLemore, Louis M. Orr, Charles R. Sias, W. Dean Steward, Robert L. Tolle, Robert E. Zellner (*Absent—Frank J. Pyle*)
PALM BEACH—Edwin W. Brown, Walter R. Newbern, Ralph M. Overstreet Jr., Cecil M. Peek (*Absent—C. Jennings Derrick, V. Marklin Johnson, Raymond S. Roy*)
PASCO-HERNANDO-CITRUS—S. Carnes Harvard
PINELLAS—Clyde O. Anderson, N. Worth Gable, Percy H. Guinand, John P. Rowell, Walter H. Winchester, Rowland E. Wood (*Absent—Curtis W. Bowman, Elmer B. Campbell Sr., Harry R. Cushman, Daniel F. H. Murphey, James E. Thompson*)
POLK—Jere W. Annis, Marion W. Hester, James T. Shelden, Edgar Watson (*Absent—James R. Boulware Jr.*)
PUTNAM—(*Absent—Lawrence G. Hebel*)
ST. JOHNS—Reddin Britt
ST. LUCIE-OKEECHOBEE-MARTIN—Richard F. Sinnott
SARASOTA—John M. Butcher, Hugh G. Reaves, Melvin M. Simmons
SEMINOLE—Terry Bird
SUWANNEE—(*Absent—Edward G. Haskell Jr.*)
TAYLOR—(*Absent—Charles R. Wiley*)
VOLUSIA—C. Robert DeArmas (*Absent—William R. Hutchison, Howard W. Reed*)
WALTON-OKALOOSA—Frederic E. Caldwell
STATE OFFICERS—Francis H. Langley, John D. Milton, Thomas C. Kenaston, Walter E. Murphree, Samuel M. Day, Shaler Richardson (*Absent—Sidney G. Kennedy Jr.*)

Dr. Langley: "There will be only one subject for discussion at this meeting and that is imple-

mentation of Public Law 569, 84th Congress, Dependents' Medical Care Act. I think most of you are fairly familiar with it, but in order that discussion can be on the basis of complete understanding, I am going to ask Dr. John D. Milton to review the provisions of the law and the necessities involved in its implementation."

Dr. Milton: "Dr. Langley, Members of the House of Delegates: I did not think that I would be coming before you again this year, however, the President has requested that I study this medical care program for the dependents of members of the uniformed services and present it to you. He also appointed a committee, headed by myself, with Drs. Jere W. Annis and S. Carnes Harvard, to study a fee schedule for the state of Florida, in case you wish to adopt it. Our committee met and made certain recommendations to the Board of Governors. I have covered this subject at the four District Meetings throughout the state and I am sure many of you have heard what I have to say. However, I must repeat it for those who did not attend the District Meetings. I am simply going to give you the background as to what prompted this law and then bring you up to date on what has happened since the law was passed and what the Board of Governors has recommended that we do at this time.

"In December of last year, we received word through Blue Shield, that the Department of Defense was considering a plan for dependents' medical care, and we were asked whether Blue Shield could handle the medical care program for dependents of the armed services in the state of Florida. Following this, there was an informal meeting of Blue Shield, the medical profession, hospitals and other interested individuals. That was held at the George Washington and, of course, no official action was taken at that time.

"Early this year, it was very definite that the Department of Defense was going to get this law passed. Later it was passed, and signed by the President on June 7.

"The Department of Defense went to Congress requesting this program for the Armed Forces because they believed it was something that was long past due. They considered it essential to the well-being of military personnel."

Dr. Milton showed a series of lantern slides explaining why the Department of Defense considered this law essential, average figures on the income of service personnel, the number of dependents to be covered, the essential provisions of Public Law 569, the scope of medical care to be provided, and the procedure for implementation of this law.

"The President appointed this committee. We met in Orlando. Before the meeting we sent a questionnaire around the state. I thought it would be too much to try to get a questionnaire back from every county society, so we divided the state into three divisions, the rural counties, the medium sized, and the larger cities. We asked some of these to tell us their average fees for certain procedures. From these questionnaires we took an average of the state on all of these procedures and we will give you that average."

A slide was shown giving the average fees for specified procedures as compiled from the questionnaires.

"We learned that the Department of Defense was leaning heavily toward the California Relative Value Schedule, so we recommended to the Board of Governors that this schedule be adopted as a working basis.

"The Relative Value Schedule is not computed in dollars and cents. It is in units of related values and from these points, a conversion factor is used to figure the dollars and cents value of the various procedures. For instance, the relative value of a hospital visit is 1; and if a conversion factor of 600 per cent is used, multiply 600 x 1, which gives $6.00. For a complete history and physical examination, the unit value is 5, which multiplied by 600 per cent, gives $30.00.

"At the committee meeting, we agreed on a conversion factor of 500 per cent for all four major categories, medicine, surgery, pathology and radiology. However, at a subsequent meeting of the Board of Governors, it was decided to recommend a little higher conversion factor. Using the California Relative Value Schedule, a conversion factor of 600 percent each was applied for medicine and surgery and 550 per cent each for pathology and radiology, and from that a fee schedule was developed which was sent to the Department of Defense. All of this, of course, was subject to final approval by this House of Delegates."

A slide was shown giving the proposed schedule of allowances for medical services.

"That is about all I have to tell you. I will be glad to answer any questions if I am able. Remember what we ask of the Department of Defense is not necessarily what we will get. In fact, we have already received a letter from Major General Robinson stating that our proposed fee schedule is too high.

Dr. Milton read the letter from General Robinson.

Dr. Milton was requested to give an explanation of the discrimination clause. He read this clause from the contract and stated that it applied primarily to the hiring of personnel in the office of the fiscal agent, and possibly the Association's office. He further stated that all doctors regardless of whether they are members of the Association, will be able to participate, as long as they have a license to practice medicine and surgery.

Dr. Gretchen Squires: "What provision is there for further negotiations for the addition of new diagnostic procedures which are not listed in the Relative Value Schedule? There are several new procedures which are not in this schedule, and it is my understanding that it is being revised. Several groups have asked that new procedures be included."

Dr. Milton: "I presume that will come through the mediation committee, which each medical association will appoint. When there is an item that is not covered in the fee schedule, it will go to the mediation team and they will negotiate these new items."

Dr. Rowland E. Wood: "It seems to me that in this fee schedule, as in our current Blue Shield fee schedule, there is an over-paying of surgeons and under-paying of the medical profession."

Dr. Milton: "Well, if so, that is something that has to be negotiated."

Dr. Burns A. Dobbins: "I don't want to perpetuate that hassle, but we can all see that medical service takes up pages 1 and 2, while the cutting doctors go from page 3 to 95; but there is an item I would like to bring up about OB procedures. Nowhere is there a provision for the care of the newborn. They provide for prematures, but not for the newborn. In many areas, the obstetrician takes care of the mother and the newborn is turned over to a pediatrician. If we could get this settled beforehand it would be helpful. Blue Shield won't pay for the care of the newborn. I hope you will consider this when you negotiate."

Dr. Milton: "Dr. Dobbins, I will say this. As for as I know, there is no limitation on the number of visits you can make, if necessary. Under Blue Shield you can only make one visit per day."

Dr. Dobbins: "Blue Shield will not pay for newborn care."

Dr. Milton: "This does take care of that. I will read you paragraph 25-c from the Joint Directive:

> " 'Necessary or required infant care shall be provided during the period of hospitalization following delivery. If the infant requires further hospitalization following delivery, such care is authorized as a continuation of the original admission. As a part of complete maternity service, newborn infant care outside of a hospital, including immunization, is also authorized at Government expense for a maximum period of 60 days following delivery but not to exceed a total of two (2) visits by a physician or to a physician after discharge from the hospital.' "

Dr. James L. Borland: "An interested group got information from the association office and went over it. We had a couple of meetings, and I have a list of some things that we have noted and some questions to be asked, with one or two suggestions. I would like to bring these up for purpose of discussion."

Dr. Langley: "If this is in regard to the fee schedule, we would like to hold it up until we get some motions on the floor. We will take it up when it is in order."

Dr. Leo M. Wachtel Jr.: "If it is in order, I would like to make a motion. You have in your hands the minutes of the Board of Governors' meeting of August 18. You also have a copy of the letter to Dr. George F. Lull, which outlined the action of the Board of Governors at this meeting, and also the meeting of September 16.

"I move the actions of the Board of Governors of the Association, with reference to civilian medical care for dependents of the uniformed services, as recorded in the minutes of the meeting of August 18, 1956 of the Board, be approved; and I further move the action of the Board of Governors at the meeting on September 16, 1956, accepting the report of the Special Committee composed of Drs. John D. Milton, S. Carnes Harvard and Jere W. Annis, on Fee Schedule, which committee developed a proposed fee schedule for Florida, using the conversion factors of 600 per cent each for the major categories of medicine and surgery, and a factor of 550 per cent each for radiology and pathology, be approved."

Seconded by Dr. Ralph Herz.

Dr. James T. Cook Jr.: "I would like to ask one question. A good many doctors in outlying communities, located near military installations, are running clinics or small private hospitals, with four or five beds for maternity cases, and I am

wondering if they are covered under this schedule. Will they be considered hospitals?"

Dr. Milton: "There is no provision that maternity has to be done in a hospital, but there are some charges about which there might be a question. Minor procedures, emergency procedures, medical treatment in the office, will not be paid for unless the patient is subsequently admitted to the hospital."

Dr. Langley: "Mr. Gibson tells me that provisions are made for delivery in the home or in the office." He then read the definition of a hospital from the Joint Directive.

Dr. Rowland E. Wood: "Dr. Langley, I would like to make an amendment to Dr. Wachtel's motion; that is, that it be adopted provided there is an adjustment in the fee schedule."

Dr. Herbert L. Bryans: "It would seem to me that this conversion factor of 600 per cent should be approved for beginning negotiations. I think what we should approve, in principle, is the Relative Value Schedule, because we can change the relative values. My suggestion would be that we approve the 600 per cent and then approve only in principle the unit values."

Dr. Henry J. Babers Jr.: "I would like to ask a question about the $15 and $25 deductions. Will the government pay that if the patient cannot or will not pay it himself?"

Dr. Langley: "I brought up that same question and Dr. Milton did not have the answer."

Dr. Milton: "That question was brought up and the task force said, 'Do you think we are going to let that girl suffer? There are certain relief funds, and if the patient doesn't have it, it will be paid.' "

Dr. W. Dean Steward: "This is socialized medicine. What we set up now is going to be used as a basis for all the patients we see. I think we are being rushed into this. The internists and pediatricians are being discriminated against because no recognition is made that they are specialists. Before this is accepted, I think it should have further study by the membership at large and not just by the Board of Governors."

Dr. Raymond H. King: "Why can't we use the present Blue Shield Schedule?"

Dr. Langley: "It is too low."

Dr. King: "I meant with a conversion factor."

Dr. Henry L. Harrell: "Aren't these people in the low and medium income brackets? I don't think we should be greedy, even in negotiations."

Dr. Robert E. Zellner: "There are two or three points I would like to make. First, these people are not indigents and there is no reason, when the Government is buying a product, that they should not pay the going rate. There is no reason why the medical profession should subsidize the Defense Department. I would like to read you an excerpt from the Board of Governors' minutes of August 18:

> 'Dr. Chrisman: Was it not your impression that the Department of Defense representatives were very sincere in their discussion in not wanting a Blue Shield attitude at any level? That is, as far as fees are concerned?
> 'Dr. Milton: This is to have no relationship to Blue Shield or any other fee schedule existing today.

and on the next page:

> 'The Department of Defense has stated that they do not want anything that looks like charity. They don't want any semi-charity.
> 'Dr. Chrisman: They think it is better for the morale of the dependents if they know the doctor is being paid a fair fee.'

"It seems to me that we should not negotiate on anything other than a fair fee basis.

"Second point. This is something which is going to last for years and years. Most of us heard about this on October 30, 31, November 1 and 2. We were asked to meet here on November 4 to decide probably the most momentous question we will ever decide in our lives. I cannot see that we are in that big a hurry. The Defense Department is, but I can't see that we need to be. This Relative Value Schedule may be fine for California, but it should not be applied to Florida. It seems to me that before you accept any fee schedule this thing should be gone into from the standpoint of Florida. We do not have to commit ourselves to some unrealistic fee schedule. If we hand them this fee schedule, they will know that we don't expect to get it. We ought to wait until we can give them a definite figure and stick by it, after we have had time to establish a definite fee schedule that we can live by.

Dr. Borland: "I believe that what we had thought about applies to this. First, we would like to have a couple of questions answered. Since a great deal of work has been spent in organizing and setting up Blue Shield, why isn't this operated through Blue Shield?

"Second, what does this inspection entail?

Whether it is the individual, the state, or the county, we feel it is perfectly proper to inspect the financial state of the books; but, on the other hand, if it is inspection and approval of professional work, we are opposed to it. If someone has to inspect, we suggest that we already have, in the Florida Medical Association and in the county societies, grievance committees, which could be organized to give inspection as it applies to professional work.

"Next, there are certain procedures on which we do not agree with the unit values. We have not had time to delineate properly the absolute values, or a manner of computing these figures, and if they are to be included they should be on a pro tem basis until they are negotiated. In this connection, it is not felt that hourly or per diem rates are proper. We also think that the unit values and the conversion factors should be reviewed annually."

Dr. Langley: "There is to be a revision in six months. After that, the contract is to be renegotiated annually."

Dr. Borland: "We believe the conversion factor and also the unit values should be reviewed. We think there should also be a provision for reviewing an individual procedure without reviewing the entire category. In other words, if you wanted to review the fee for an appendectomy, you would not have to review the whole surgical schedule. We feel there should be some safeguards so that we can negotiate and not be tied to this thing. Also we believe that if we accept this relative value schedule, we must accept the philosophy which has been outlined. Most of the discussion which has occurred is covered in the basic philosophy of the California plan. We should not divorce the fee schedule from the philosophy."

Dr. Collins: "The Orange County delegation had a meeting on Friday night with the Executive Council to come prepared with a concrete plan. It was felt that we should not go up to Washington with an inflated fee schedule. That would put us in a bargaining position which would make us look pretty small. I was surprised to hear that a letter had already been written about the $6.00 conversion factor. We feel that this is too high in caring for people of the medium income group. We do not feel they should be charged more than we charge our patients at home. I believe I am allowed to offer a substitute motion.

"I move that the House of Delegates first approve the resolution of cooperation with the Federal Government which the Board of Governors passed at their meeting on August 18. Second, the selection of Blue Shield as our fiscal agent. Third, that Dr. Milton be authorized to go to Washington to negotiate, using a conversion factor of 460 per cent for surgery and 500 per cent for each of the other major categories; that he also negotiate for a cancellation clause; that he negotiate for the right of renegotiation of this contract at stated intervals; that he report back to a second meeting of this House of Delegates the results of his negotiations before any final action is taken, and finally, that a committee of three representative men from each of the groups involved, and three general practitioners, be appointed to study the relative values in their fields and report back to the House of Delegates."

Seconded by Dr. Harvard.

Dr. Langley decided to vote on Dr. Collins' motion point by point. He called for a vote on the first and second points of the motion, both of which carried.

Dr. Simmons: "Dr. Langley, you did not allow any discussion on that second point. I would like to know why Blue Shield was selected as our fiscal agent. I understand that there were two other agencies, the Association and the Medical Service Bureau that could have served."

Dr. Langley: "Blue Shield is under the control of the Florida Medical Association's House of Delegates. It was also felt that they have a better physical set up than the Florida Medical Association. It was thought that it is better to keep it in an organization which is under our control."

Dr. H. Phillip Hampton: "If a discussion of Blue Shield is in order, I would like to inquire of Blue Shield if the recommendations of the Florida Medical Association have been put into effect. It became obvious to us at the Blue Shield meeting that although the House of Delegates is designated the body of Blue Shield — the body of Blue Shield cannot make a motion."

Dr. Carson: "The motions which were presented at the active membership meeting, the annual meeting in Miami Beach last year, have been referred to committee and are being studied at the present time. No final action has been taken."

Dr. Hampton: "I believe that we are in accord that the body of Blue Shield is the House of Delegates, and if that motion goes through

and they do, in fact, make the House of Delegates the corporate body with power to act, then we are safe in having Blue Shield as our fiscal agent. If not, the fiscal agent will be a corporate body over which the House of Delegates has no control."

Dr. Steward: "I don't see how we can send a man to Washington to negotiate when it is not final. I don't see any point in giving him a conversion factor because the relative values may not be at all acceptable."

Dr. Jere W. Annis: "I think we should tell John to negotiate on a temporary basis, for a given length of time, until this schedule can be worked out, using a 500 per cent conversion factor, which is what the committee recommended."

Dr. Cecil M. Peek: "There is another phase of this matter that I would like to say something about. Certainly, Dr. Milton is the best man to represent us, and we are grateful to him for the work he has done, but I am wondering if we should send just one man. It seems to me that he would welcome some help."

Dr. George W. Morse: "Is it correct now that Dr. Milton is not due there until November 16 instead of tomorrow?"

Dr. Milton: "I am due there at 8:30 tomorrow morning."

Dr. Cleveland: "Isn't December 7 the day that this goes into effect?"

Dr. Langley: "Regardless of what we do, it goes into effect on December 7."

Dr. Cleveland: "Isn't the alternative that if we don't decide on something, the Defense Department will just tell us what we will get?"

Dr. Annis: "I wonder if Dr. Collins will accept as an amendment to his motion that our representative be authorized to negotiate with the Department of Defense on the basis of a conversion factor of 500 percent for all major categories. I suggest that this be negotiated for a period of three months, to give us time to work out a definite schedule."

Dr. Cook: "I feel we are being rushed into a fee schedule without knowing how far out of line it will be. None of us is so greedy that he can't wait for his money. Why can't we say that we will take care of these people and ask them to give us two or three months to work out a satisfactory schedule. Then we will negotiate."

Dr. Langley: "It is necessary for the Defense Department to negotiate some kind of contract so that they can get out directives to the various armed services."

Dr. Collins: "I would like to accept Dr. Annis' amendment to my motion."

Dr. Langley: "What was that amendment?"

Dr. Annis: "That our representative be authorized to negotiate with the Department of Defense on the basis of the California Relative Value Schedule with a conversion factor of 500 per cent on each major category on a temporary basis not to exceed three months at which time we would offer a more complete schedule."

Dr. Squires: "May I ask Dr. Annis to accept one word of correction to his amendment — to place the word 'Revised' before the California Relative Value Schedule?"

Dr. Langley: "Do you think they would agree to renegotiate in three months when they are going to revise all of the contracts in six months?"

Dr. Milton: "Frankly, I don't think we should send anyone to negotiate without limitations on what to negotiate. I would not accept the responsibility of going carte blanche. I could not do it without some definite limitations."

Dr. Sidney Stillman: "The AMA is usually our bargaining agent. Is the AMA entirely out of this?"

Dr. Langley: "They have been very much in it up to the present time but the idea is to negotiate contracts with the individual states. They have been working night and day. The AMA task force working with the task force of the Department of Defense has made nine revisions of the implementation of this law."

Dr. Milton read Sec. 202 of Public Law 569.

Dr. Zellner: "I would like to point out one difficulty that Dr. Annis' amendment introduced into the substitute motion. A part of that motion says that a committee will be appointed to meet and revise this schedule. Three months is a very short time in which to get a fee schedule together. If we can get it together in six months we will be very fortunate."

Dr. Langley: "Since it is up for review in six months do you think that is necessary?"

Dr. Annis: "We can say, we don't know whether this is a good schedule or not. We will sign up temporarily until we can review it."

Dr. Morse: "I would like to say a word in regard to Jere's amendment. You will remember that we were going to renegotiate Blue Shield. It has never gotten to the point where all members of our Association are receiving proper benefits. Blue Cross goes up and Blue Shield hasn't gone up since it was originally started. The internists and pediatricians are dissatisfied and even

the surgeons are dissatisfied. I think this is most important to us because it is the entering wedge of socialized medicine — call it what you will. I have a strong feeling that renegotiation in six months is not going to amount to anything. I think it would be better to have them go to Washington with the schedule as we want it. Certainly if we adopt too low a schedule it will not be long before the commercial insurance companies will think that it is what we think each procedure is worth. I would like to see the House of Delegates delay for a week or so."

Dr. Borland: "What we are interested in is that every individual procedure may be renegotiated and revised as to its relative value in addition to the unit valuation, and if this is the proper place for that amendment, I would like to move that in the negotiations a phrase be included which would permit negotiation of a single procedure, or of each individual procedure, upon suitable demand."

Dr. Steward: "There are many points that cannot be settled today. Would it be possible to agree that we will take care of these patients, that we will work out a fee schedule and not sign anything until we work out something agreeable. I see no reason why we should sign away our birthright."

Dr. Langley: "I think we have to admit that the Government is working in good faith. They are not happy about rushing this through but Congress did it without any idea of the work involved. We have to assume a certain amount of good faith on their part because they don't know where they are anymore than we do."

Dr. Collins: "I think three months is ample time for three men from each group to go over this and figure out the correct unit values. I believe we will be in better position to do this on our own rather than wait for six months and allow the government to negotiate. I would say do it within three months and approve or disapprove what we want."

Dr. Langley: "I am still at a loss as to what you want to do about tomorrow morning. This is up for negotiation in about 19 hours."

Dr. Collins: "The only thing Dr. Milton can do tomorrow is to offer to negotiate on a $5.00 conversion factor on the Revised California Relative Value Schedule.

Dr. Wachtel: "I move the privilege of the floor be given to Mr. Harry T. Gray."

Motion seconded and carried.

Mr. Gray: "I am Harry Gray, attorney. On some of your discussion, I think I might be of help by referring to some of the provisions of the contract. The negotiations tomorrow morning will go into two fields, one the legal field of determining whether or not these provisions are fair and agreeable from the standpoint of your announced fiscal agent, Blue Shield, and from the standpoint of the Florida Medical Association, and, second, negotiation of a fee schedule which will be advantageous to members of the profession. Some of the questions you have asked go into the legal field rather than the medical field. In the contract which has been proposed it is stated that the fiscal agent shall obtain a report from a physician submitting a bill for procedures or services rendered which are not specifically indicated on the Schedule of Allowances. Fees for unusual or unlisted procedures shall be submitted to a committee of the Association which will make a recommendation to the contracting officer and within 20 days if he does not object it is accepted as the fee schedule for this unusual procedure.

The contract will terminate at a certain date and you are not bound by any schedule that Dr. Milton has agreed to. It will then be required that a new contract will be negotiated annually. The government runs on a fiscal year which ends on June 30."

Mr. Gray went on to explain the legal provision of the contract.

Dr. Wachtel: "In order to include in the motions that have previously been made — I believe Dr. Collins agreed on authorization for Dr. Milton to go to Washington to negotiate a contract. Dr. Peek has mentioned, and there are a number of doctors here who feel it is too great a burden to place on one man, and I would like to ask Dr. Collins to accept as an amendment to his motion or that portion of his motion —

Dr. Lowenthal: "I think at this point we have all reached a state of confusion. I believe it would be much simpler to vote on Dr. Collins' motion for the purpose of defeating it, and go back to the original motion with the amendment."

Dr. Reaves: "I move that the substitute motion be tabled."

Seconded by Dr. Lowenthal.

Motion carried.

Dr. Reaves: "I move that the original motion be tabled."

Seconded by Dr. Zellner.

Motion carried.

(Continued on page 821)

OTHERS ARE SAYING

Taking Notes at Medical Meetings

We have been impressed recently, not only with the tremendous number of note-taking techniques employed at medical meetings, but with the startling revolution our own note-taking has undergone. There was the day when we went to medical meetings with much note-taking paraphernalia including at least two never-fail mechanical pencils, that always managed to fail, and against the failure of which we also carried a freshly filled fountain pen. (In reviewing some of our old notes, however, it appears that a pencil can fail and the writer not become aware of it, for some of our notes appear only as indentations in the paper — no lead, notes taken in the dark.)

Then there was a refinement in note-taking; the flashlight. This required that a flashlight be added to a pocket already bulging with writing gear. When the lecturer demanded that the lights be turned out so he could show his slide, the note-taker grasped the flashlight and its switch in the left hand, his pencil (we assume it is still functioning) in the right hand, and somewhere between elbows, left forearm, knees and anterior aspects of thighs, managed to grip the note-book and proceeded to take notes. There was always something satisfying in writing prettily under these circumstances; many of our notes were prettier than what we do sitting a la Palmer method at a desk. But a super-refinement came. The combination pencil (or pen) and flashlight. This took the whole note-taking business out of the realms of technique and reduced it to a semi-automatic mechanical process. It left too much time to think about the subject matter and has led directly to the degeneration of our note-taking. Degenerate it did from here on.

As soon as our mind was occupied only with what the lecturer was saying and doing, and the mechanics of note-taking no longer provoked the invigorating thrill of masterly exercise of a technical skill, we found our notes going along well for a line or so, then the words became more scrawly; finally, the words trailed to the vanishing point and were nothing, absolutely nothing. This was not as unsettling as it sounds, for we soon developed a lethargic, contented sort of satisfaction in the technique of dozing in a well-illuminated room without the lecturer or neighbors giving overt evidence of being aware of our sleeping. True, once in a while our technique slipped, and a neighbor was constrained to nudge an interruption to what he would later allege was noisy respiration, but, in a general way, we continued to bask in the self-satisfaction that comes from attending lots of medical meetings, der ewige Student type of reputation. Note-taking in itself, you see, had become as effortless as we'd like to have everything else in this life. . . .

This brings us back to the good old method requiring no special equipment, available to all of us from the lowest type of specialist to the highest type of provincial physician, namely, alternate dozing and note-taking with a blunt stub of a pencil on the back of a tattered envelope. It gives you just as much satisfaction as any other method, takes just as much know-how, and will be read and referred to just as often and with equal yield as any flossier technique. And what's more, it gives time to observe that alert gent in the front row who listens eagerly, whose eyes fairly glitter with the joy of the game, and who gets up after the talk and, with obvious enjoyment, intelligently punches holes in the lecture and the lecturer.

H. G. M.

—Minnesota Medical Journal, March 1955

BIRTHS AND DEATHS

Births

Dr. and Mrs. Joseph H. St. John, of Jacksonville, announce the birth of a daughter, Helen Frances, on November 25, 1956.

Dr. and Mrs. Daniel L. Stone, of Miami, announce the birth of a daughter, Irene Kay, on October 26, 1956.

Dr. and Mrs. Charles F. Biggane Jr., of Miami, announce the birth of a daughter, Barbara Lynn, on November 26, 1956.

PHYSICIANS AND PSYCHIATRISTS FOR CALIFORNIA STATE STREAMLINED EMPLOYMENT PROCEDURE: By interview only (no written examinations). Interviews held periodically in California and nationwide. Wide choice of positions in 15 large State hospitals, institutions, and veteran homes. 40 hour week, liberal vacation, and other benefits including generous retirement annuities. Annual salary increases. Three salary groups: $10,860 to $12,000; $11,400 to $12,600; $12,600 to $13,800. Candidates must be U. S. citizens and in possession of, or eligible for, California license. For full information write to Miss Carmack, Supervisor, Medical Recruiting, Box A, State Personnel Board, 801 Capitol Avenue, Sacramento, California.

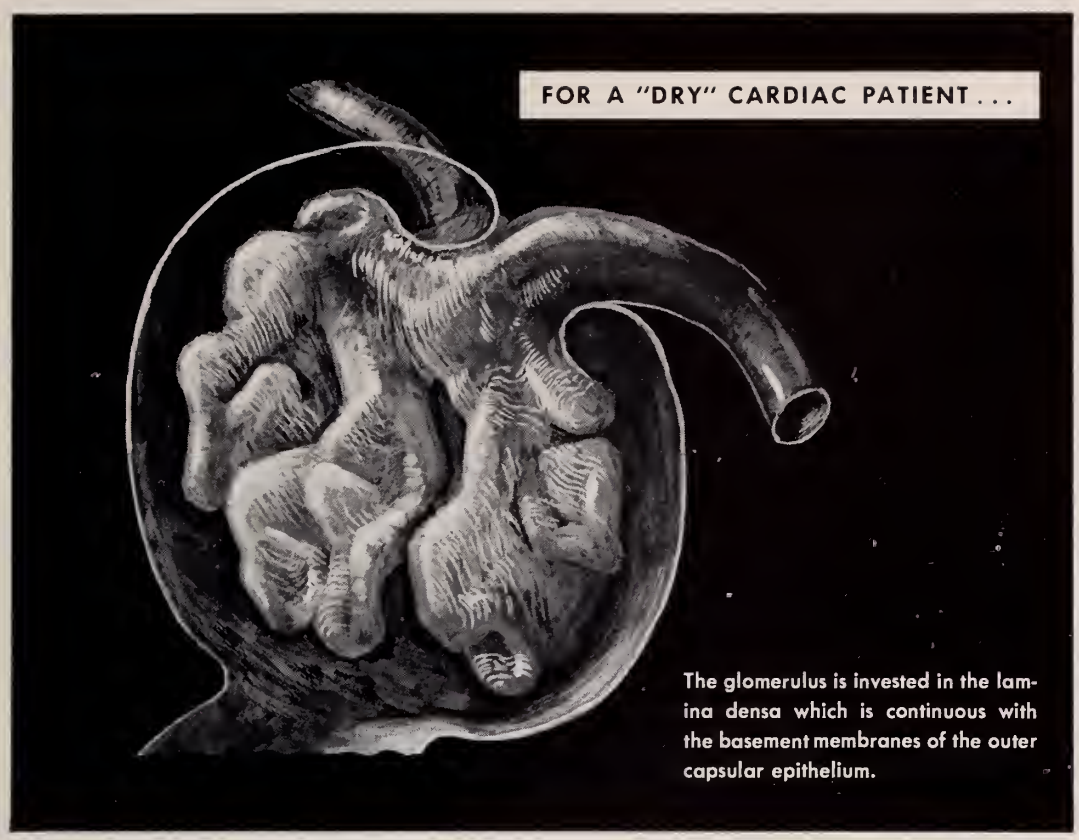

Illustration by Hans Elias

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". . . the drug represents a most useful addition to our armamentarium in the treatment of edema, not only because it can be given orally . . . but more so because it permits [us] to replace or to spare the . . . mercurials."[3]

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

1. Asher, G.: Personal communication, June 23, 1956.
2. Settel, E.: A Clinical Evaluation of a New Oral Diuretic, Rolicton, Postgrad. Med., Feb. 1957, in press.
3. Goldner, M. G.: Personal communication, June 29, 1956.

SEARLE

Dr. and Mrs. Paul E. Howard, of Miami, announce the birth of a son, James Hall, on November 28, 1956.

Dr. and Mrs. David Kirsh, of Miami, announce the birth of a daughter, Madeline, on November 28, 1956.

Deaths — Members

Farley, Frank J., Dade City	December 1, 1956
Nobles, William D., Pensacola	October 3, 1956
Owens, John H., Orange Park	November 24, 1956

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Anderson, Donald C., West Palm Beach
Bechtold, John E., West Palm Beach
Brooks, William, Miami
Brown, Roy W., Belle Glade
Butt, Cecil G., Orlando
Carron, Jonas, Tampa
Chandler, Howard C., Jacksonville
Conners, James J., Jacksonville
de la Penha, Daniel S., Tampa
Dunsford, Ensor R. Jr., Jacksonville
Edwards, Joshua L., Gainesville
Farrior, Richard T., Tampa
Garth, Thomas H., Tampa
Gonzalez, Arturo G., Tampa
Haddad, Maurice, Tampa
Hubener, Louis F., Gainesville
Iglesias, Robert G., Tampa
Jennings, Lloyd H., Starke
Lasche, Eunice M., Tampa
Martin, Samuel P., Gainesville
Morse, Irwin S., Coral Gables
Nelson, Arthur R., Jacksonville
Pedrero, Edward Jr., Tampa
Pierleoni, Ernest E., Hialeah
Szekely, Gabriel, Miami Beach
Unger, Harold M., Miami
Wright, John T., Tampa

COMPONENT SOCIETY NOTES

Dade

A panel discussion of "Medical Management of Peptic Ulcer" was the program for the January meeting of the Dade County Medical Association. Dr. Donald F. Marion, of Miami, was moderator. Discussants included Drs. Robert A. McNaughton and Emil M. Isberg, of Miami; Dr. John M. Rumball, of Coral Gables, and Dr. Kirby Martin, of New York City.

Duval

Drs. Paul V. Reinartz and John F. Lovejoy, of Jacksonville, and Mr. R. B. Donaldson, also of Jacksonville, were principal speakers at the January meeting of the Duval County Medical Society. The entire program was devoted to answering the question: "Do doctors want to be covered by social security?"

Dr. Reinartz is medical director of the South Central Home Office of the Prudential Insurance Co. of America. Dr. Lovejoy is vice president of the Union Life Insurance Co. and Mr. Donaldson is district manager for the Social Security Administration.

Jackson-Calhoun

The regular quarterly meeting of the Jackson-Calhoun County Medical Society was held December 6 at Blountstown. Dr. Henry I. Langston, of Marianna, and Dr. Grayson C. Snyder, of Blountstown, were hosts. Special guests included Dr. Lorenzo L. Parks, of Jacksonville.

Pinellas

"Medical Witnesses in Court" was the principal topic for discussion at the January meeting of the Pinellas County Medical Society held at Madeira Beach. Following the presentation of a film on the subject, discussion and comment was led by Judge Victor O. Wehle in cooperation with Dr. Irvin S. Leinbach.

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STATE NEWS ITEMS

The Twentieth Annual Meeting of The New Orleans Graduate Medical Assembly is being held March 11-14 at New Orleans with conference headquarters in the Municipal Auditorium. Features will be lectures, symposia, clinicopathologic conferences, round-table luncheons, medical motion pictures, scientific and technical exhibits. The postclinical tour this year is to the Mediterranean and Europe with departure from New York on March 16.

For information concerning the Assembly and the tour, contact Secretary, Room 103, 1430 Tulane Ave., New Orleans 12.

Dr. David A. Newman of Palm Beach has been elected a Fellow of the American College of Physicians and becomes a life member of the College.

Dr. A. Fred Turner of Orlando was in Atlanta in December attending a meeting of a special fact-finding committee of the Southeastern Section of the American Urological Association.

The Fifty-Second Annual Meeting of the American Trudeau Society will be held in Kansas City, Mo., May 6-9, in conjunction with the annual meeting of the National Tuberculosis Association. In addition to scientific sessions, plans are being made for seven special lectures and four panel discussions.

Dr. Hyman J. Roberts of West Palm Beach recently concluded a course in electrocardiography and cardiology at the St. Mary's Hospital, West Palm Beach. This was the second such course sponsored by the Section on General Practice of the Palm Beach County Medical Society.

Dr. Hawley H. Seiler of Tampa has been reelected secretary-treasurer of the Southern Thoracic Surgical Association.

Dr. Robert V. Artola of West Palm Beach has returned to that city after attending the scientific session of the Association of Seaboard Airline Railway Surgeons in New Orleans, and the meeting of the Florida Obstetrical and Gynecological Society in Nassau.

Dr. Francis T. Holland of Tallahassee has been appointed state chairman for Florida of the

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World Medical Association, according to announcement by Dr. Louis H. Bauer, secretary-treasurer of the Association.

Dr. William M. C. Wilhoit of Pensacola has been elected first vice president of the Florida Association for Mental Health. At the recent annual meeting of the National Association for Mental Health held in Washington, D.C., Dr. Wilhoit served as an official delegate from Florida.

Applications for postdoctoral fellowships in rehabilitation, psychiatry, orthopedics, management of poliomyelitis, preventive medicine and for training in research and/or academic medicine are being received by the National Foundation for Infantile Paralysis until the deadline on March 1. Information on the fellowships may be obtained from the Division of Professional Education, National Foundation for Infantile Paralysis, 120 Broadway, New York 5.

Drs. Wilbur C. Sumner and Alvan G. Foraker of Jacksonville have been awarded a research grant of $2,300 by the National Cancer Institute for a study of immunological properties of the blood of patients with regressed melanoma. The Institute has awarded a separate grant to Dr. Foraker and Dr. Sam W. Denham for a study of experimental tumors of the ovary.

Dr. G. Dekle Taylor of Jacksonville and Dr. Sherman B. Forbes of Tampa attended the recent annual meeting of the American Academy of Opthalmology and Otolaryngology held in Chicago.

The Academy of Medicine of Cincinnati has cordially invited the physicians of Florida and their families to its 100th Birthday Party, February 27 through March 5. In order to officially observe the occasion, a Health Museum and Exposition will be established in Cincinnati's spacious and historic Music Hall.

The Sears-Roebuck Foundation is again calling attention to its Revolving Assistance Fund established for the purpose of making loans to physicians desiring to establish or improve medical facilities in areas where the medical care is inadequate. In a recent announcement, the Foundation stated that the program is not confined

(Continued on page 812)

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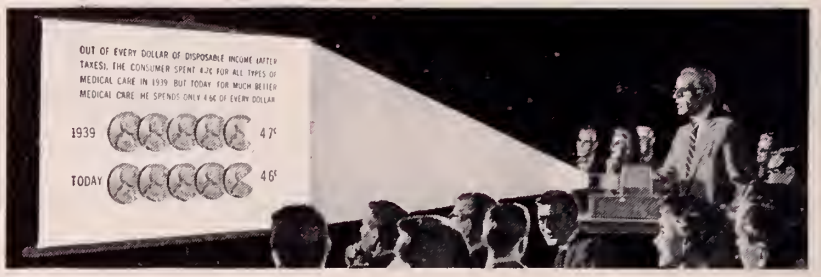

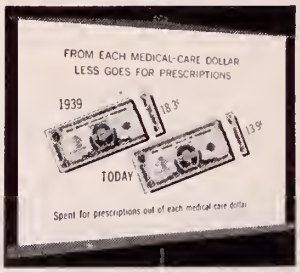

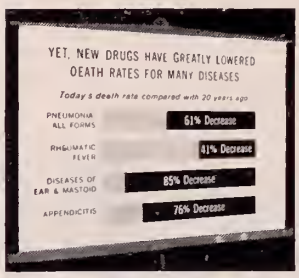

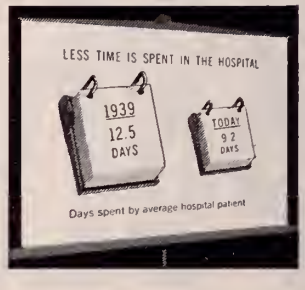

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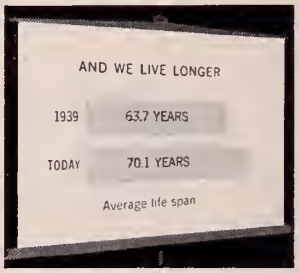

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(Continued from page 808)

strictly to rural practice but is also to include suburban areas.

Application forms may be obtained from the Foundation, 3333 Arthington St., Chicago.

Dr. Sherman B. Forbes of Tampa has been elected chairman of the Southern Section of the Association for Research in Ophthalmology. The election took place at the recent annual meeting of the organization in Washington, D.C.

The interim meeting of the Florida Society of Neurology and Psychiatry was held the last of 1956, the scientific program in the Alcoholic Rehabilitation Center at Avon Park and the social events in the Chalet Suzanne at Lake Wales. Dr. Lorant Forizs, clinical director of the state alcoholic rehabilitation program, was principal scientific speaker. Some 40 members of the Society attended the event.

Dr.. Sullivan G. Bedell of Jacksonville has been elected president of the Florida District Branch of the American Psychiatric Association. Dr. James L. Anderson of Miami is the vice president and Dr. Samuel G. Hibbs of Tampa secretary-treasurer.

Dr. Hugh B. Goodwin Jr. of Fort Pierce has been elected secretary of the general practice section of the Southern Medical Association.

Dr. William W. Richardson of Graceville has returned from Boston where he did postgraduate work in electrocardiography.

Dr. Maltby F. Watkins of Fort Pierce is president of the newly formed St. Lucie County Chapter of the Florida Academy of General Practice. Other officers are Dr. Alfred J. Cornille, vice president, and Howard C. McDermid, secretary-treasurer. Both Dr. Cornille and Dr. McDermid are from Fort Pierce.

Applications for research grants from funds made available by the Florida Heart Association will be received until the deadline of March 1, according to announcement by Dr. Jere W. Annis, of Lakeland, chairman of the Association's Research Committee. The grants are to be evaluated during the month of March and final allocations will be made as of the time of the Association's annual meeting in May. Applications should be sent to the Florida Heart Association, 2427 Central Avenue, St. Petersburg.

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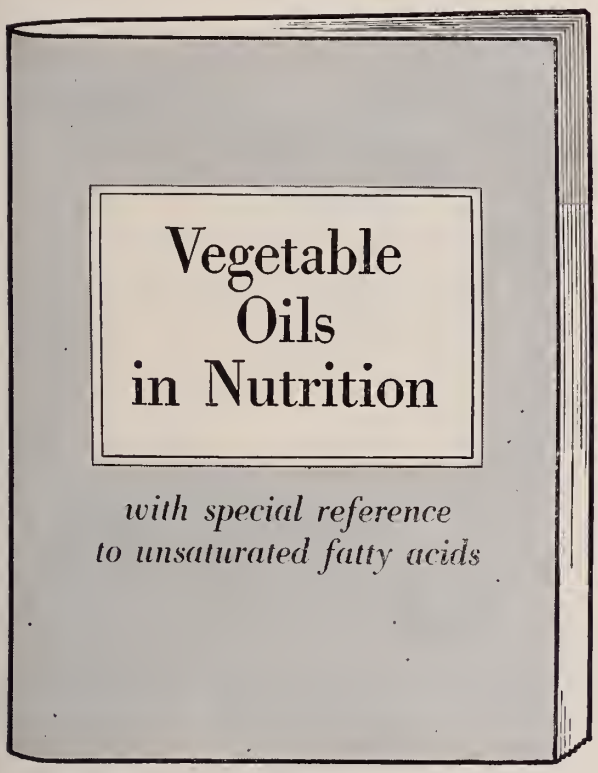

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OBITUARIES

LeRoy B. Elliston

Dr. LeRoy B. Elliston of Fort Lauderdale died at his home on June 18, 1956, after a long illness. He was 71 years of age.

A native of Illinois, Dr. Elliston was born at Senachwine Lake in Putnam County on May 4, 1885. He matriculated in the University of Illinois in 1904 and was awarded the degree of Doctor of Medicine by the College of Medicine of that institution in 1909. That same year he entered the general practice of medicine at Magnolia, Ill. In 1917, he entered the Army and served in the Expeditionary Forces in both England and France during World War I.

Upon completion of his military service, Dr. Elliston limited his practice to surgery. In 1934 he came to Florida from LaSalle, Ill., and located in Fort Lauderdale. He set up a joint practice there with his brother, Dr. R. L. Elliston, which continued until the fall of 1950 when illness forced his retirement from active practice. Locally, Dr. Elliston was a thirty-second degree Mason. He held membership in the American Legion and was a member of the Kiwanis Club.

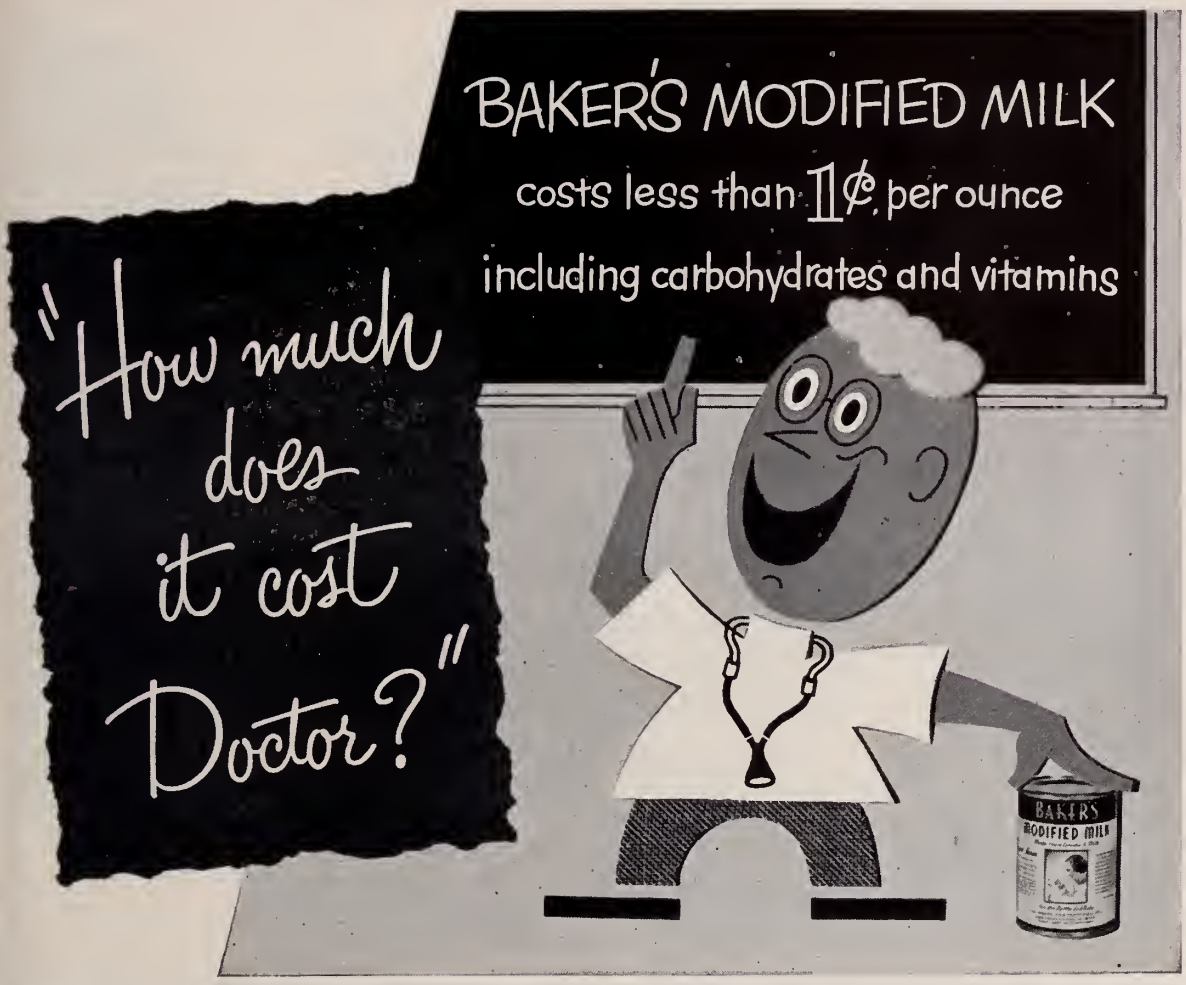
A member of the Broward County Medical Association, Dr. Elliston had held membership in the Florida Medical Association since 1935. He was also a member of the American Medical Association for many years.

Surviving is the widow, Mrs. Ida Wurst Elliston. Other survivors in addition to his brother, Dr. R. L. Elliston, include three sisters, Mrs. G. A. Anderson, of Fort Lauderdale, Mrs. C. A. Forbes, of Bradford, Ill., and Mrs. Marguerite Feurer, of Rockford, Ill.

Robert Baskin Harkness

Dr. Robert Baskin Harkness of Lake City died in the Lake Shore Hospital in that city on Sept. 21, 1956, following a heart attack suffered the night before. He was 84 years of age. Interment took place in Elmwood Cemetery, Birmingham, Ala., on September 25.

Born in Clinton, Ala., on March 2, 1872, Dr. Harkness received his elementary education there. After graduation from Marion Institute at Marion, Ala., he entered Tulane University School of Medicine in New Orleans, where he was awarded the degree of Doctor of Medicine in 1897. He first engaged in the private practice of medicine in



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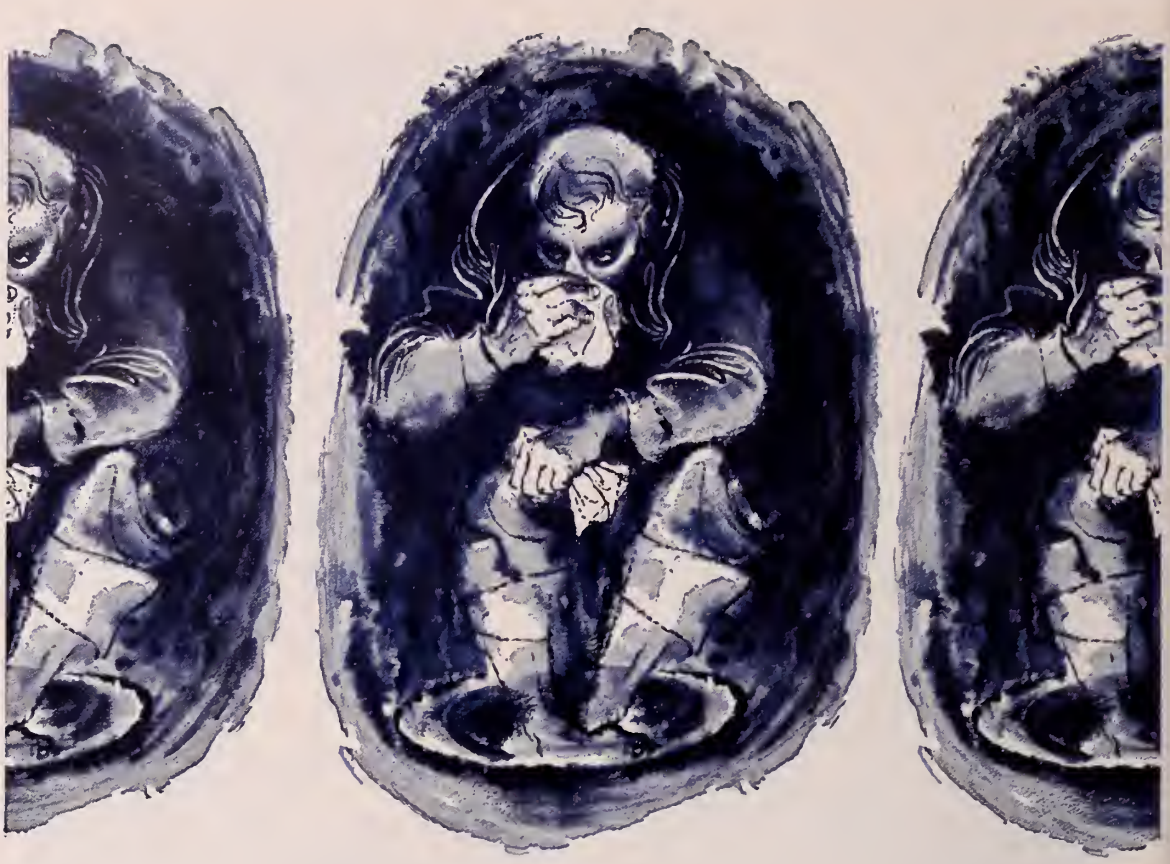

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Newcastle, Ala., and later located in Birmingham, where he was visiting surgeon at St. Vincent's Hospital from 1902 to 1905. In 1905 he was appointed as the first health officer of Birmingham and served in that capacity until 1909, when he resigned. During that period he also was Associate Surgeon at the Long-Harkness Hospital. From 1908 to 1911 he was surgeon in the Hillman Hospital.

In 1911, Dr. Harkness located in Lake City, where he continued to practice medicine and surgery for 45 years. He assisted in a major operation only a few hours before his death. Beginning in his own home soon after he arrived in the community, he operated hospital units in Lake City and Watertown and continued as superintendent of the present Lake Shore Hospital from the time it was completed in 1937 until his death nearly 20 years later. Locally, Dr. Harkness was a member, deacon and treasurer of the First Presbyterian Church and a charter member of the Rotary Club and of the Chamber of Commerce. He also was a member of the Childrens' Home Society of Florida.

Dr. Harkness was a member and past president of the Columbia County Medical Society. A life member of the Florida Medical Association, with which he had been affiliated for 44 years, he was also a member of the American Medical Association and the Southern Medical Association. He was a fellow of the American College of Surgeons.

Survivors include his widow, Mrs. Hazel Harkness, of Lake City; one son, Robert B. Harkness Jr., of Lake City; and six nieces, Mrs. Lewis Green, of Lake City; Miss Elizabeth Hix, of Baltimore, Md.; Mrs. Mary Burke, of Washington, D. C.; Mrs. Wilson Barnes, of Miami; Mrs. Everrete Owens, of Aliceville, Ala., and Miss Sarah Horton of Wauchula.

Prescott H. LeBreton

Dr. Prescott H. LeBreton of St. Petersburg died on July 26, 1956, in Middletown, N. Y., while on a visit there. He was 84 years of age. Interment took place in St. Petersburg.

Born in Patterson, N. J., in 1872, Dr. LeBreton received his medical training at the Columbia University College of Physicians and Surgeons in New York, where he was graduated in 1896. He then served an internship in Roosevelt Hospital in New York for two years and later practiced in Buffalo, N. Y., before coming to Florida.

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Dr. LeBreton was a member of the Pinellas County Medical Society and through the years entertained at many medical society functions on the organ and piano, as he was an accomplished musician. He presided at the organ for many graduation exercises for nurses. While residing in Buffalo, he was for many years organist of a large church there.

An active member of the Florida Medical Association for 20 years, Dr. LeBreton since his retirement in 1949 had held honorary status. He also held membership in the American Medical Association, the Southern Medical Association and the American Orthopedic Association, and was a fellow of the American College of Surgeons.

Married to the late Lillian Elizabeth McCue LeBreton, who died in St. Petersburg in 1951, Dr. LeBreton is survived by two daughters, Miss Alida LeBreton and Miss Etty LeBreton, both of Buffalo, and a cousin, Miss Ruth Sutherland, of Pine Bush, N. Y., and St. Petersburg.

House of Delegates

(Continued from page 799)

Dr. Langley: "That leaves us right back where we started, with a clean sheet of paper. Will someone make a motion calling for approval of the resolution of cooperation with the Federal Government."

Dr. Simmons: "I so move."

Seconded by Dr. Ralph Herz.

Motion carried.

Resolution

Representing the Florida Medical Association, its Board of Governors agrees with the policy of the American Medical Association, that in this country military dependents, like all other civilians, should be treated by pri-

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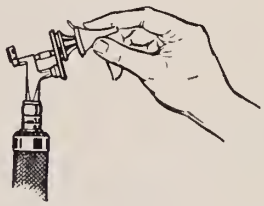

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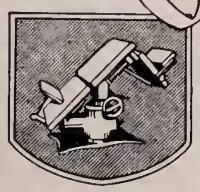

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vate physicians in civilian hospitals, unless these resources are inadequate or unavailable.

In accordance with this policy, the Florida Medical Association will endeavor to follow the lead of the American Medical Association in carrying out the provisions of Pubic Law 569, 84th Congress.

We expect a spirit of cooperation by all parties which will preserve the freedom of both the patient and the physician, and the private practice of medicine.

Dr. Langley: "I would like to ask for a motion expressing approval of the Board of Governors' selection of Blue Shield as our fiscal agent."

Dr. Hampton: "I so move."

Seconded by Dr. Herz.

Motion carried.

Someone asked if this motion will hold if Blue Cross and Blue Shield do not accept the recommendations made by the House of Delegates.

Dr. Langley: "It will hold for six months."

Dr. Langley: "Now we come to the matter of the development of the proposed fee schedule as outlined in the letter of September 24 to Dr. George F. Lull. We stated that the Board of Governors recommended that we negotiate on the basis of the California Relative Value Schedule, purely on the basis of practicality because there was no time to work out a fee schedule."

Dr. Borland: "I move that the revised California Relative Value Schedule be used as the basis for negotiations."

Seconded by several voices.

Motion carried.

Dr. Zellner: "I move that the negotiators be given a floor, or a minimum of 500 per cent conversion factor on which to negotiate."

Seconded by Dr. Hampton.

Discussion followed.

Dr. Roberts: "Dr. Milton, what do you think the minimum conversion factor should be?"

Dr. Milton: "I certainly do not want to tell the House of Delegates what to do. How many of you know that we now have a contract with the Federal Government?"

Dr. Milton held up a copy of the Veterans Fee Schedule. Only a few hands were raised in answer to his question. He then read a few of the fees listed in the V.A. Fee Schedule.

Dr. Collins: "I would like to amend Dr. Zellner's motion to 460 per cent for surgery and 500 per cent for the other services."

Dr. Zellner accepted this amendment.

Dr. Kennedy: "If you get into 4.6 or 3.2 or any fractional figure, the bookkeeping will become

rather complicated. I think our committee should have some range if they are going to negotiate, say between 500 and 650 per cent. I would like to make an amendment to the motion that they have a range between 500 and 650 per cent, with a floor of 500. Dr. Milton asked for a range and we are not giving him a range, we are only giving him a floor. I recommend that we stay away from small fractional figures. I would like to make an amendment to the amendment that the floor be 500 and the top 650 per cent."

(Not seconded.)

Dr. Langley: "The fee schedule will be completely worked out, just like the Blue Shield fee schedule, with the fees computed in round numbers to the nearest dollar. There will be no fractional figures to complicate the bookkeeping."

Dr. Milton: "We should hear from Dr. Orr, who has been sitting here quietly. He has a wealth of information which will be of great value to us."

Dr. Orr: "I believe that the whole point of this trip tomorrow is this. Dr. Milton goes, Mr. Gray goes, and Mr. Gibson goes. There will be no other physician there, other than the man who has been present at all the negotiations, the assistant director of the AMA Washington Office, Dr. Kennard. He will meet this group prior to the conference in the morning. He will give them a great deal of guidance. I hope you won't hamstring Dr. Milton with figures. You are there to make a deal. Dr. Kennard will be there, and in room 806 at the Statler Hotel will be some legal counsel from the A.M.A., Mr. Hirsch. He will meet with this group tonight. I don't want to be thrown out of this building, but I prophesy that you will sign for a figure of 4.4. From what I know of Capt. Noel, he is very fair-minded and will try to do a good job that will be acceptable to all concerned. The law provides that this can be renegotiated next June 30. Then, if you go another year, any time within 120 days past any fiscal year, you can renegotiate. To give you an idea of how much difficulty there has been in negotiating, let me read you the list of those who have signed contracts: Colorado, Washington, Indiana, Oregon have formally signed. Negotiations completed, but contracts not yet signed: California, Minnesota, Michigan, New York, Wisconsin, North Dakota, North Carolina, Connecticut, Massachusetts, Maryland, New Jersey,

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New Hampshire and Vermont. Most states in the latter group have agreed to fee schedules and contracts, with final action awaiting official approval of state societies. In some cases a few problems still remain to be settled, but the Defense Department anticipates no critical delay in any of these states. This is from an AMA Washington Letter.

"Dr. Milton should be allowed to get a fair deal. Don't try to get everything but don't get too little. Someone has mentioned who is paying for this—just remember it is coming out of your pockets. This is only the door opening a little wider on that great unknown which we have feared for so long—but it is with us—the law is on the books and we have to live with it."

"I have been asked about the osteopathic situation. If Michigan does not sign through their Blue Shield as fiscal agent, I understand that Walter Reuther is offering his own Blue Shield. You must remember that in Government service, osteopaths are now commissioned in the Armed Services on a permissive basis, which means that they may be commissioned, but they are not yet commissioning any."

Dr. Borland: "I would like to suggest a surgical schedule of 428 per cent and medicine of 450."

Dr. Zellner: "This is for negotiation. No contract is to be signed. Dr. Milton can come back and tell us what to do. I don't accept this amendment."

Dr. Borland: "He should be able to complete the negotiations, but we ought not to put it to the point where he has to get up and walk out. He could have a suggested figure of 500 per cent or 475 per cent, but the minimum range should be such as to allow him to complete negotiations, which I understand would be 428 on surgery and 450 on the others."

Dr. Holland: "Dr. Milton has done a world of work on this problem. We feel that we can trust him, that he is not going to sell us short, and if we hamstring him he will have to get up and walk out. I would like to move that we table the motion."

Seconded and carried.

Dr. Holland: "I move that this house of Delegates go on record as appointing Dr. Milton as our negotiating officer, to go to Washington and bring back to this association the results of his negotiations to be accepted at that time."

Seconded by Dr. Maines.

Dr. Borland: "I think we should accept Dr. Milton's statement that he needs a floor."

(Continued on page 832)

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*Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, Am. J. Digest. Dis. 18:59 (Feb.) 1951.

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A 27-year-old man, a chronic alcoholic, was admitted with a history of an alcoholic spree followed by a cough, greenish sputum and chills and fever.

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The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 48 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.[1]

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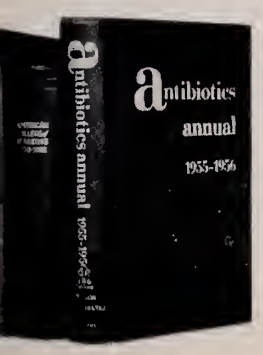

1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48.
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M. A.M.A. Archives of Internal Medicine, 1954, p. 556.

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(Continued from page 824)

Dr. Milton: "I would feel better if you give me a floor."

Dr. Roberts: "Let's give Dr. John Milton and Dr. Louis Orr about five minutes to have a conference and make recommendations."

Dr. Holland: "I withdraw my motion."

Dr. Britt: "I move that they have a conference."

Seconded and carried.

Dr. Langley: "In order to save time, would you like to take up certain changes in the relative value schedule which you feel are not in line."

Dr. Squires: "This will surprise you. We want to lower certain fees, which we feel are too high. Routine tissue examination, gross or microscopic, is given a value of 4 points, which would be $20.00. We would like to change this to 2 points, which would bring it down to $10.00. Cytologic study of Papanicolaou smear is given a value of 3 points, which would make it $15.00, which seems to be excessive; we ask that the Papanicolaou smear be put at 1 point or $5.00 level. There are a few other changes, I am sure Dr. Patterson can give you some of them, but they are relatively minor."

Dr. Dobbins: "I don't think we have time to take these up now. To change the point values in some categories would be unfair to the rest of us. We should wait until we have a committee."

Dr. Langley: "The question comes up whether on short order we should make an effort to revise the relative value schedule."

Dr. Borland: "I would like to move that the information be conveyed to the Government that we are not satisfied with the Relative Value Schedule, and that we will study it and it will be renegotiated when we have finished our study."

Seconded by Dr .Harvard.

Dr. Morse: "I would like to see that motion defeated. There has not been time enough to consider this following the district meetings. I realize that it is impossible to go through all of these this afternoon, but I realize some of the societies have checked some of the things which are glaring inequities. I think it is much better if we can change them and call this our Florida system which is revised.

Motion carried.

Drs. Orr and Milton returned to the room and Dr. Orr stated that Dr. Hampton would give their report.

Dr. Hampton: "I move that Dr. John Milton be authorized to negotiate with the Department

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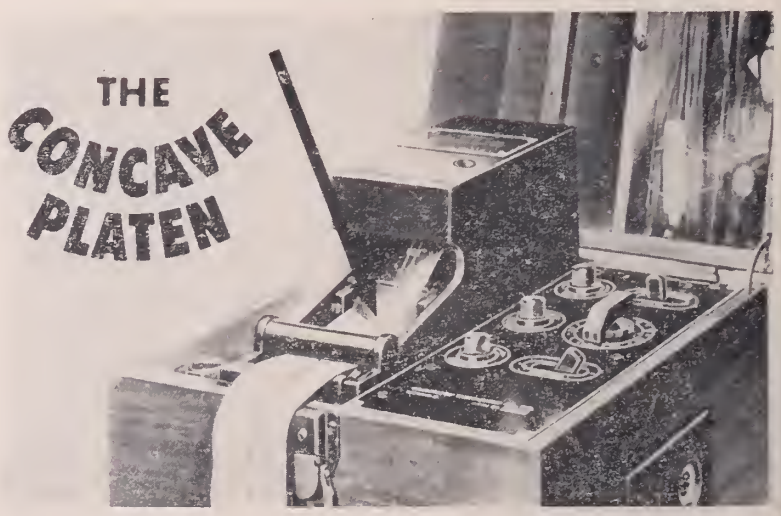

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1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954

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of Defense for the fee schedule for the doctors of Florida using a minimum conversion factor of 440 per cent for surgery and 500 per cent for each of the other categories of medicine, radiology and pathology."

Seconded by Dr. Frazier J. Payton.

Motion carried.

Dr. Langley: "Escambia County delegation wants to be heard a little more on revising the relative value points on certain procedures."

Dr. Bryans: "Escambia County had a meeting and the medical men, radiologists, and pathologists got together. Dr. Squires has told you about the pathologists. The medical men want some changes made; namely, consultation requiring complete examination, to be changed from 7 units to 10 units. They also want a hospital visit changed from 1 to 1.4. Otherwise, the relative values of the California schedule were approved as far as the men practicing medicine are concerned."

No action taken.

Dr. Langley: "Dr. Milton has been authorized to go to Washington to negotiate with the Government. He has not been authorized to sign a contract. I think at this time we should arrange for another meeting of the House because I can see no other group with authority to sign."

Dr. Corso: "I move that the next called meeting of the House of Delegates be held at the same place as the last regular meeting was held, at a time which will be sufficient to consider Dr. Milton's report."

Seconded by Dr. Dobbins.

Motion lost.

Dr. Murphree: "I move that since we have given Dr. Milton a floor that if he obtains that floor or better he be authorized to sign a contract."

Seconded by Dr. Rogers.

Motion carried.

Dr. Langley: "Do you wish to leave it to my discretion to call another meeting of the House of Delegates, if necessary?"

Dr. Hampton: "I move that the president be authorized to call another meeting of the House of Delegates in the event that Dr. Milton does not decide. I also move that the President be authorized to appoint three members from each major category, and three general practitoners. to consider the relative value units."

Seconded by Dr. Harvard.

Dr. Langley: "For clarification, do you mean three from each specialty group or three from each of the four major classifications?"

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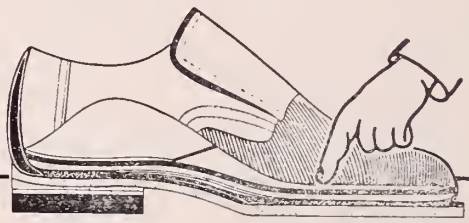

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Dr. Hampton: "Three from each classification listed in the nomenclature from the Department of Defense, and three general practitioners."

Motion carried.

On motion by Dr. Hanson, seconded and carried, the meeting adjourned at 1:40 p.m.

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Auxiliaries Busy on Projects

Florida's 23 county auxiliaries are working on local, state and national projects. February sees intensification and increased enthusiasm each year for the work to be done before the state convention in May and prior to the convention in June of the national auxiliary.

Mrs. Scottie J. Wilson, President, Woman's Auxiliary to the Florida Medical Association, has been visiting county auxiliaries and will continue during February and March and probably into April. She reports understanding and greater determination to do a fine job on all projects this year.

Seminole County Auxiliary has taken Mental Health as their number one project this year and are hard at work on it. Dade and Duval

(Continued on page 843)

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Make your pause at work
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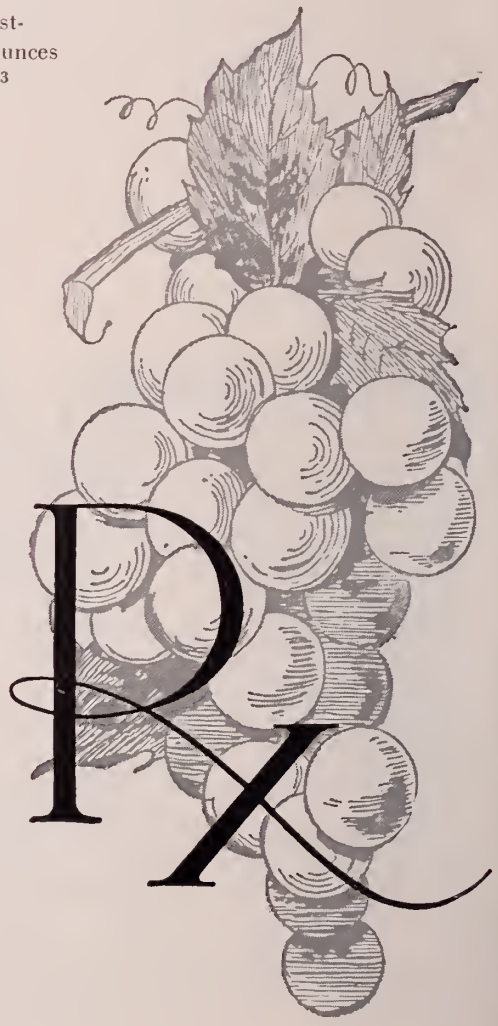

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2. Irvin, D.L., and Goetzl, F.R.: Permanente Found. M. Bull. *9*:119 (Oct.) 1951.
3. Irvin, D.L.; Durra, A., and Goetzl, F.R.: Am. J. Digest. Dis. *20*:17 (Jan.) 1953.
4. Goetzl, F.R.: A Note on the Possible Usefulness of Wine in the Management of Anorexia, unpublished.

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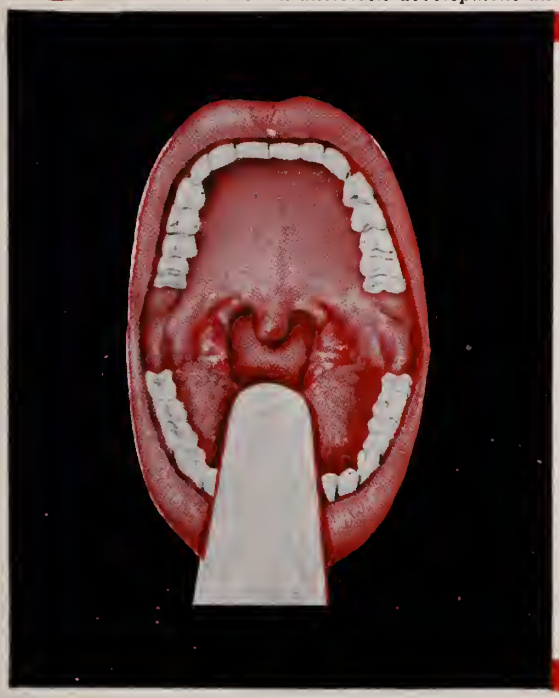

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1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51.

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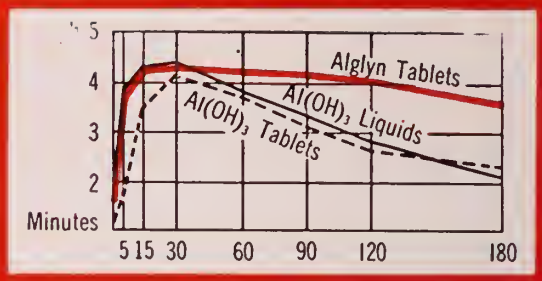

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Reprint of recent *in vivo* studies available on request

1. Rossett, N.E. and Rice, M.L., Jr.: Gastroenterology, 26:490, 1954.
2. Hammarlund, E.R. and Rising, L.W.: J. Am. Pharm. Assoc., Scientific Edition, 33:586, 1949.

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(Continued from page 836)

Counties are stressing the American Medical Education Foundation along with other projects and hope to do their share in raising $2500, our goal this year.

Hillsborough County is interested in Safety among other projects and has a representative on the Hillsborough County Safety Council. Along with the other county auxiliaries, Hillsborough is very active in the Recruitment Program, particularly nurse recruitment, and our number of Future Nurses Clubs is growing in all sections of our state.

Members of all county auxiliaries have been active in helping the various voluntary health agencies, both in fund raising and other projects. Tuberculosis, Poliomyelitis, Cerebral Palsy, Heart, Cancer, Diabetes, Red Cross, Community Chests and Mental Health are all recipients of this help at local, state and national levels.

Reports indicate that our auxiliaries are working on the needs of their communities and counties. In most instances there is definite leadership and interest in obtaining those facilities and programs that will benefit the health and welfare of the total population.

As membership of the Florida Medical Association increases, increases in membership in the Florida Auxiliary are evident, too. Chances look good for increase of over 100 members this year and outside chances for an increase of over 200 members. More doctors' wives are becoming aware of the results of organized effort and more are becoming really active members of the auxiliary. Though it might be to the embarrassment of the doctors to say so, in many instances, attendance at auxiliary meetings surpasses the number of doctors who attend their county medical society meetings. A study would probably show that interest and enthusiasm among the doctors' wives for their programs and projects is equal if not above that of the doctor. How about that, Doctor?

With the season in full swing, house guests everywhere, and the doctors' wives burdened by calls for help from other community organizations, we still see increased activity and participation in our medical auxiliaries throughout the state. This, in itself, speaks for the worth of what we do and the interest we have in it. Spring being just around the corner, we all look forward to the convention in May and to bigger and better reports of activity than ever before.

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We have considered other terms but have at last agreed on *cell examination for uterine cancer* as the term which simply and accurately describes the keystone of this vitally important program.

This test can help save thousands of women each year. In many parts of the country it is becoming widely accepted as a part of a routine checkup. As fast as county medical societies approve, our local Units will urge women to go to their physicians annually for a *cell examination for uterine cancer.*

AMERICAN CANCER SOCIETY

BOOKS RECEIVED

The Stress of Life. By Hans Selye. Pp. 325. Price, $5.95. New York, McGraw-Hill Book Company, Inc., 1956.

This book represents a unique contribution to better understanding of the body and how it reacts to disease — for both scientist and layman. Dr. Hans Selye has been acclaimed throughout the world by scientists, physicians and psychologists for his brilliant exposition of the stress theory. He has written many books and articles addressed to students and specialists in medicine. This is his first book written for the general public. Here, in language easily understandable by the general reader, the man who has been called "the Einstein of medicine" explains his modern stress concept. He gives the layman authoritative information about the medical aspects of stress in health and disease as he explains his remarkable and revolutionary discoveries.

The creator of the now famous G.A.S. concept of stress, proving that the reaction of the body to an outside agent is often far more important than the agent itself, takes the reader into his confidence and unravels the incidents, experiments and thinking that developed this most recent milestone in medical research. With high good humor and keen understanding of, and sympathy for, human nature, he brings one a vivid and dramatic realization of the work of a medical researcher and how discoveries affecting the future health and well-being of all humanity are made. The practical applications of the book are many. It brings new light to bear on the nature and effects of disease, how the body reacts to the wear and tear of living, and what to do to adjust more harmoniously to such depletion of "adaptive energy."

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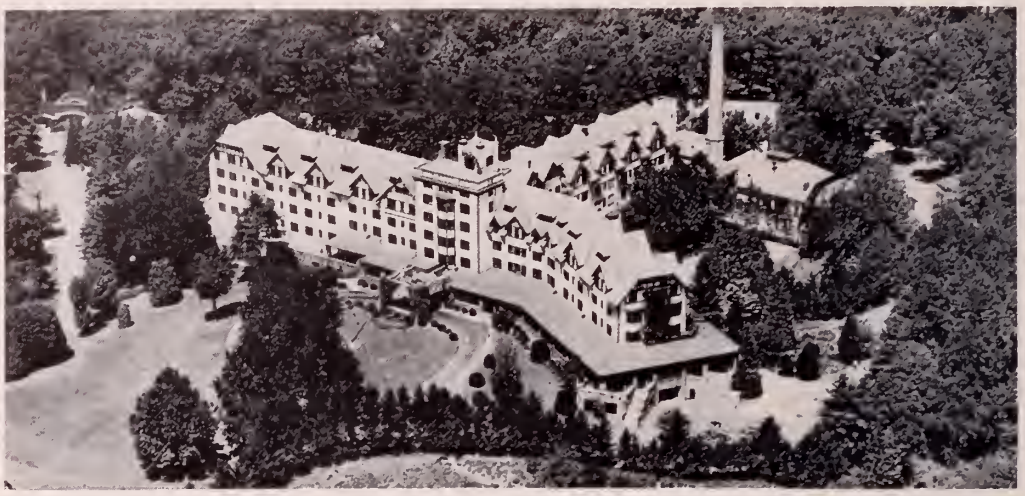

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**Bradford, Gilchrist, Union*				
Bay	John J. Benton, Panama City	Lloyd B. Harrison Jr., Panama City	1st Tues.	
Brevard	Myron L. Habegger, Rockledge	Louis C. Jensen Jr., Cocoa	2nd Tues.	
Broward	Walter J. Glenn Jr., Fort Lauderdale	Garland M. Johnson, Fort Lauderdale	4th Tues.	
Collier	James A. Craig, Naples	Ethel H. Trygstad, Naples	3rd Wed.	
Columbia	Thomas H. Bates, Lake City	Laurie J. Arnold Jr., Lake City	1st Mon.	
**Baker*				
Dade	Walter W. Sackett Jr., Miami	Vincent P. Corso, Miami	1st Tues.	
DeSoto-Hardee-Highlands-Glades	Godfrey L. Beaumont, Sebring	Theodore W. Weeks Jr., Sebring	1st Tues.	
Duval	Leo M. Wachtel Jr., Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	
**Clay*				
Escambia	Paul F. Baranco, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	
**Santa Rosa*				
Franklin-Gulf	Photis J. Nichols, Apalachicola	William F. Wager, Port St. Joe	Last Wed.	
Hillsborough	Madison R. Pope, Plant City	James A. Winslow Jr., Tampa	1st Tues.	
Indian River	Walter W. McCorkle, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	
Jackson-Calhoun	William W. Richardson, Graceville	Francis M. Watson, Marianna	Quarterly	
Lake	Fred A. Vincenti, Mount Dora	J. Basil Hall, Tavares	1st Wed.	
**Sumter*				
Lee-Charlotte-Hendry	James L. Bradley, Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	
Leon-Gadsden-Liberty-Wakulla-Jefferson	George S. Palmer, Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	
Madison	Julian M. DuRant, Madison	A. Franklin Harrison, Madison		
Manatee	Joseph A. Gibson, Bradenton	Warren G. Darty, Palmetto	2nd Tues.	
Marion	John D. Lindner, Ocala	Robert L. Gibson, Ocala	3rd Tues.	
**Levy*				
Monroe	Robert W. Reid, Key West	Joseph J. Scarlet, Key West	1st Thurs.	
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Orange	Frank J. Pyle, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	
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Polk	John P. Tomlinson Jr., Lake Wales	Charles Larsen Jr., Lakeland	2nd Wed.	
Putnam	Alfred P. Peretti, Palatka	Norman B. Egerton, Palatka	2nd Tues.	
St. Johns	Milton Segal, St. Augustine	William J. Gibson, St. Augustine	3rd Tues.	
St. Lucie-Okeechobee-Martin	John M. Gunsolus, Stuart	Adrian M. Sample, Fort Pierce	3rd Thurs	
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Suwannee	Hiram B. Curry, Jasper	William P. Blackmon, Jasper	1st. Sat.	
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Taylor	Charles R. Wiley, Perry	Ralph J. Greene, Perry	Last Fri.	
**Dixie*				
Volusia	Arthur Schwartz, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	
**Flagler*				
Walton-Okaloosa	Ralph B. Spires, DeFuniak Springs	Howard A. Parker, Valparaiso	3rd Tues.	
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1. Knoch, H.R., and Kirk, R.: Proclorperazine—A New Agent for the Treatment of Psychic Stress, in manuscript.

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Vol. XLIII MARCH, 1957 No. 9

Eighty-Third Annual Meeting
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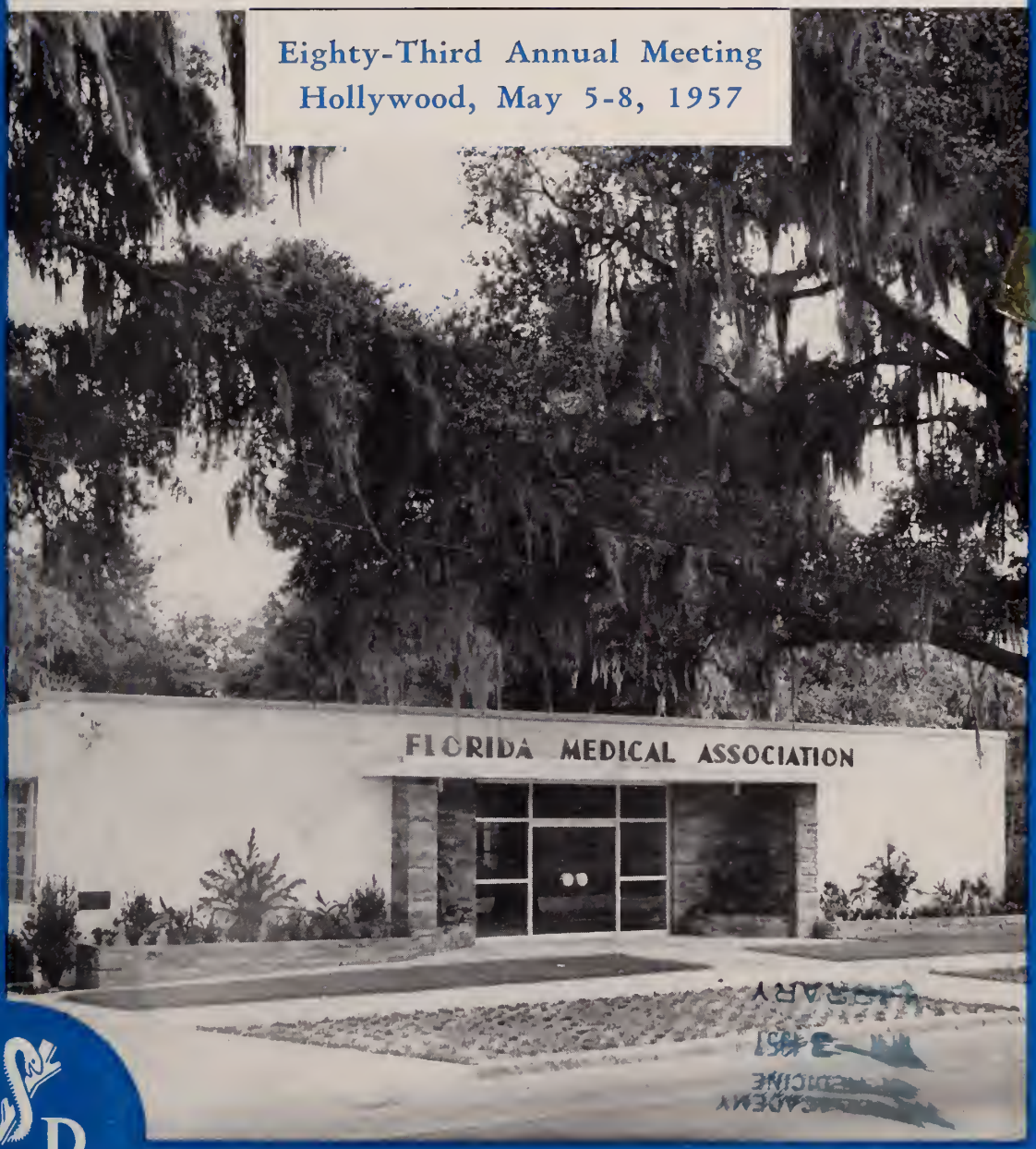

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CHLOROMY

COMBATS MOST CLINICALLY SIGNIFICANT PATHOGEN

OUTSTANDING EFFICACY OVER THE YEARS

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REFERENCES

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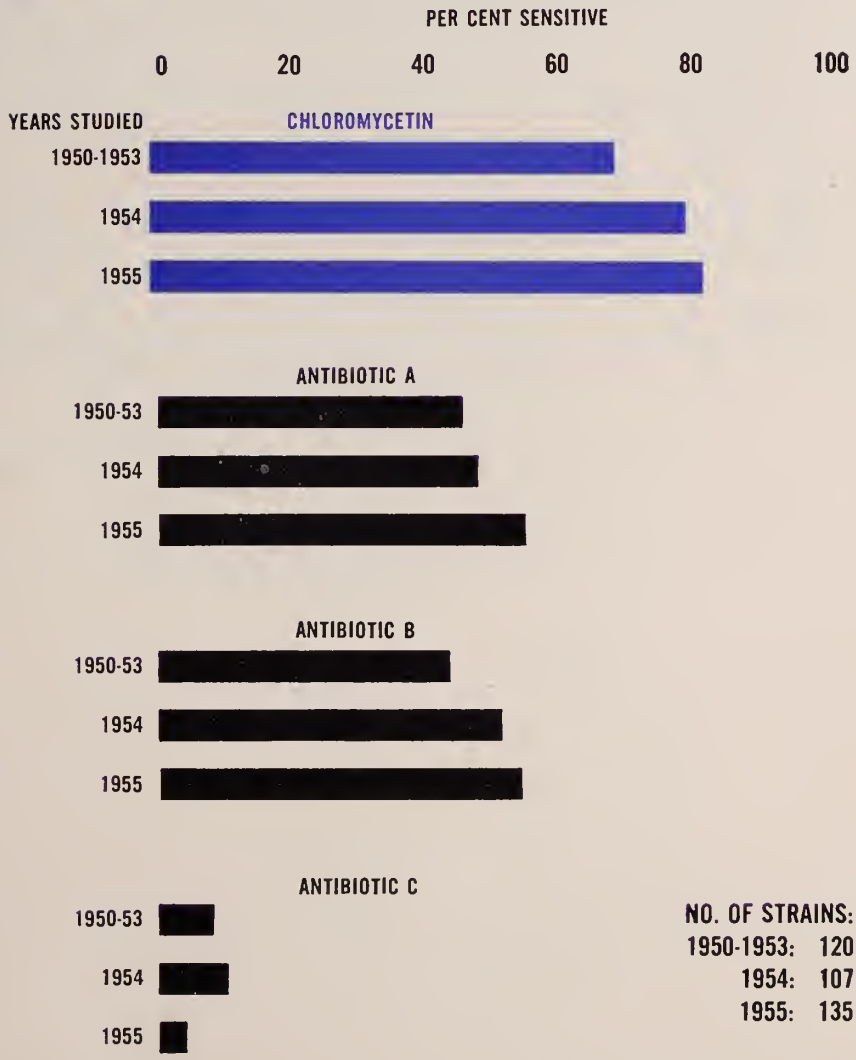
PERCENTAGE OF NONRESISTANT STRAINS OF STAPHYLOCOCCUS AUREUS SENSITIVE TO CHLOROMYCETIN AND THREE OTHER MAJOR ANTIBIOTIC AGENTS*



NO. OF STRAINS:
1950-1953: 120
1954: 107
1955: 135

*This graph is adapted from a five-year study by Rantz and Rantz.[n]

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those caused by antibiotic-resistant
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reactions are rare at recommended

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have been reported following
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Unique physiologic barrier—topical amino acids—brings rapid relief (98%[1]) and complete healing (88%[1])

"...the objectives of therapy in pruritus ani can be listed under 3 headings:

(1) relieve itching: [Hydrolamins produced immediate relief of intractable itching in 98% of patients. The antipruritic effect of one application lasts about twenty-four hours.[1]]

(2) accelerate healing, [Hydrolamins rapidly and completely healed reddened, fissured, macerated and ridged perianal lesions in 88% of cases.[1]]

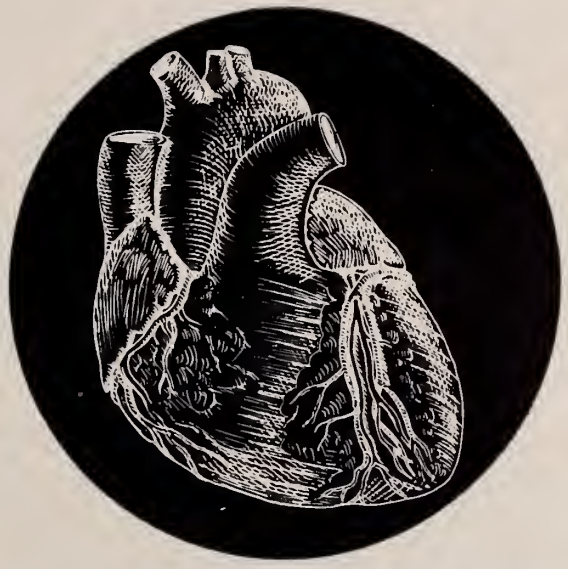
(3) allow natural healing without trauma due to physical, chemical, allergic, or microbiologic agents."[2] [The amino acids of Hydrolamins promote safe, natural healing while the ointment protects the perianal area from irritation.[1]]

Due to the rapidity of action of Hydrolamins, it is believed that protein-precipitating irritants, responsible for the pruritus, are neutralized. Hydrolamins also forms a biochemical barrier against further irritation.

SUPPLIED: In 1 oz. and 2.5 oz. tubes.

Lewal *Pharmaceutical Company*, *Chicago 14, Illinois*

1. Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, Am. J. Digest. Dis. 18:59 (Feb.) 1951.
2. Fromer, J.L., Dermatologic Concepts and Management of Pruritus Ani, Am. J. Surg. 90:805 (Nov.) 1955.



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Thiamine mononitrate	1.0 mg.
Riboflavin	1.0 mg.
Niacinamide	5 mg.
Pantothenic acid (Panthenol)	1.5 mg.
Pyridoxine hydrochloride	0.5 mg.

Alcohol content: 12 per cent

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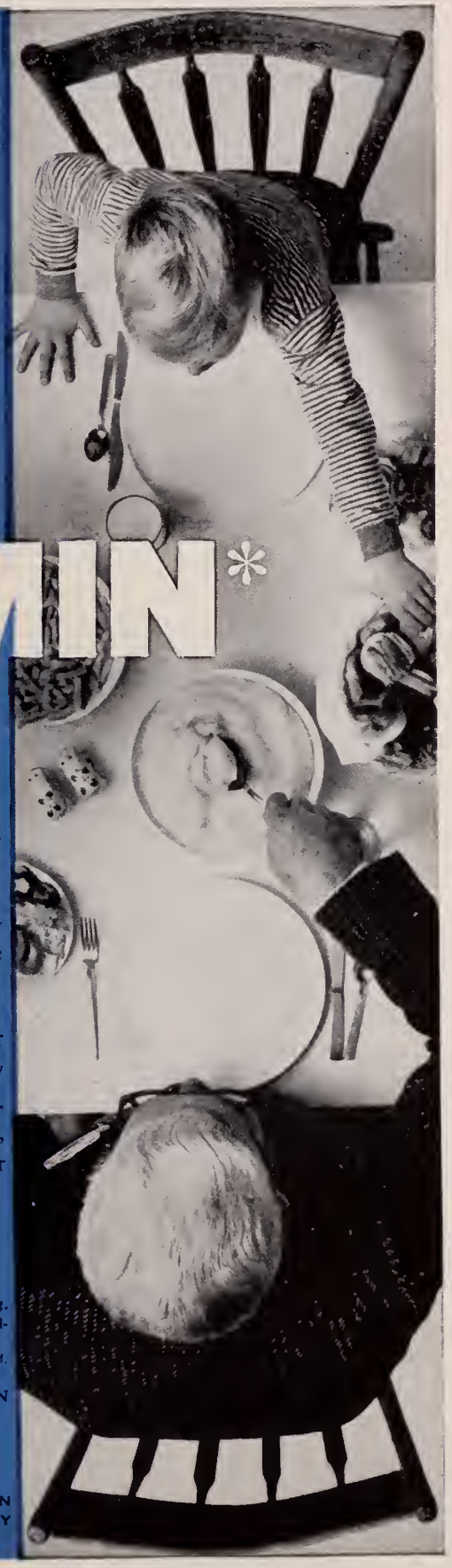

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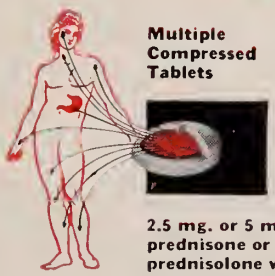

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References: 1. Boland, E. W., *J.A.M.A.* 160:613 (February 25) 1956. 2. Margolis, H. M. *et al., J.A.M.A.* 158:454 (June 11) 1955. 3. Bollet, A. J. *et al., J.A.M.A.* 158:459 (June 11) 1955.

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Use of Ganglionic Blocking Agents in Treatment of Severe Essential Hypertension

MORTON M. HALPERN, M.D.
MIAMI

A persistently elevated diastolic blood pressure affects the cardiovascular system adversely. It is the primary cause of arteriolar damage, cardiac strain and cerebral and renal impairment. Large arteries become inelastic. Hypertrophied arterioles contract excessively.[1] Left ventricular hypertrophy, strain and heart failure eventuate. Consequently, if the morbidity and mortality of hypertensive patients are to be improved, steps must be taken to lower blood pressure in those patients in whom degenerative changes secondary to the hypertension are demonstrated.

Of the numerous hypotensive agents available over the years, the relatively new ganglionic blocking agents are the only ones potent enough to lower blood pressure effectively and practically in a high percentage of cases of severe essential hypertension. Recent reports are most encouraging.

Approximately 5 per cent of the adult population has hypertension,[2] and in over 90 per cent of the cases the disease is classified as essential hypertension after elimination of all known causes. Only a small proportion of the cases of essential hypertension requires the use of these ganglionic blocking agents.

Mode of Action

Ganglionic blocking agents interrupt or decrease the sympathetic outflow from higher nervous centers to the effector vascular sites. Upon this action depends their therapeutic effect.

Hypertension results from the increased peripheral resistance secondary to a narrowing of the terminal vascular bed, primarily the arterioles of the systemic circulation. Theoretically, this narrowing may be due to an excessive sympathetic discharge, a circulating substance or metabolic change, a structural change in the vessels, or an increased reactivity of the vasomotor complex due to ordinary stimuli.[3] Regardless of the theoretic etiology, however, it is now known that a therapeutic drop in pressure results from sympathetic blockade.

The action of the ganglionic blocking agents is at the sympathetic ganglions, where they compete with acetylcholine for receptor sites located on postganglionic neurons, thereby blocking the transmission of impulses across the sympathetic synaptic junctions. Unfortunately, this same mechanism operates at other cholinergic sites and accounts for the atropine-like action on peripheral viscera causing undesirable side effects, which will be discussed later in this report.

The therapeutic result of ganglionic blockade depends primarily on the orthostatic hypotensive effect due to removal of compensatory sympathetic vascoconstriction in the upright position (fig. 1). At the same time, the uniform vasodilatation of the arterioles can maintain a lower blood pressure level in all positions. There are also decreased venous pressure, venous inflow, and cardiac output.

Medication

It has been our practice at The Hypertensive Clinic of the Jackson Memorial Hospital in Miami to treat all patients initially with a Rauwolfia preparation alone for at least two to four weeks and then to continue it along with the ganglionic blocking agents. This seemed to facilitate the control of the blood pressure levels.

Currently there are four ganglionic blocking agents available for clinical use (fig. 2). Three of them are quaternary ammonium compounds: hexamethonium (six carbon chain between the nitrogens), pentolinium* (five carbon chain be-

From The Hypertensive Clinic of The Jackson Memorial Hospital and The University of Miami School of Medicine.
Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami Beach, May 14, 1956.

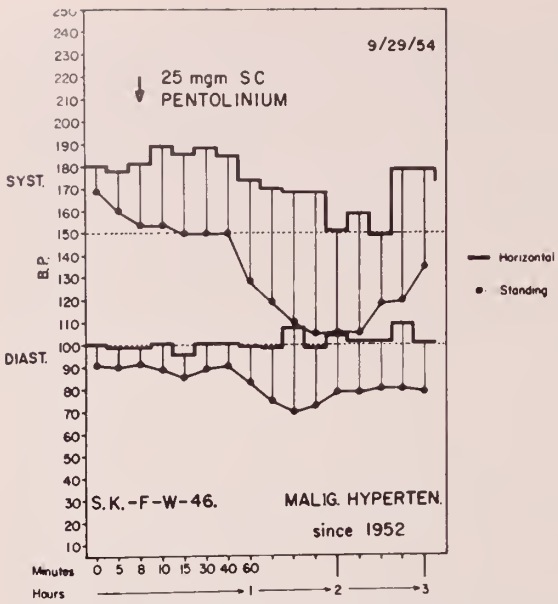


Fig. 1. — In a case of malignant hypertension which was reversed, the blood pressure chart demonstrates an acute experiment with subcutaneous pentolinium. Note the orthostatic hypotensive effect (dots) as compared with the blood pressure in the supine position (horizontal lines).

tween the nitrogens), and chlorisondamine† (two carbon chain separating quaternary nitrogens). The fourth preparation, mecamylamine‡, is a secondary amine.

Hexamethonium was the first available ganglionic blocking agent that was practical clinically for hypertension. Now, however, in most clinics its oral use has been discontinued because of its excessively severe constipating effect, variable absorption from the gastrointestinal tract, and unpredictability. There have been cases of severe constipation, ileus with a shocklike state, renal shutdown, and death resulting from overdosage with hexamethonium. Also several fatal cases of interstitial pneumonia were reported during the early years of its use.[1] The other three agents are currently being evaluated at the clinic.

The hypotensive effect of oral pentolinium (Ansolysen) lasts for approximately eight hours; therefore, it is administered three times a day, usually before breakfast, at bedtime and in the middle of the afternoon (fig. 3). It is available in 20, 40 and 100 mg. tablets, the initial dose being the smallest tablet with increments of 20 mg. every other day until the desired hypotensive effect is obtained. Chlorisondamine (Ecolid) comes in 25 and 50 mg. tablets. The initial dose is 25 mg. given about every 12 hours, the approximate duration of action, and increased by 25

* Supplied as Ansolysen by Wyeth Laboratories, Inc.
† Supplied as Ecolid by Ciba Pharmaceutical Products, Inc.
‡ Supplied as Inversine by Sharp & Dohme (Division of Merck & Co., Inc.)

HEXAMETHONIUM BROMIDE (OR CHLORIDE)

CHEM. - HEXAMETHYLENEBIS (TRIMETHYLAMMONIUM BROMIDE OR CHLORIDE)

PROP. - BISTRIUM (Br.) (SQUIBB), METHIUM (Cl) (WARNER-CHILCOTT), HEXAMETON (Cl) (BURROUGHS WELLCOME), ESOMID (Cl)(CIBA) (NO PATENT)

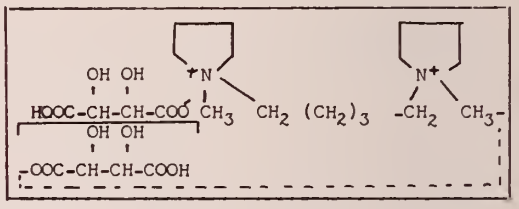
$(CH_3)_3N^+-CH_2(CH_2)_4CH_2N^+(CH_3)_3\ 2\ Cl^-$

DESCRIP. - SYMMETRICAL 6 CARBON QUATERNARY AMMONIUM CMPD.

PENTOLINIUM TARTRATE (M & B 2050)

CHEM. - PENTAMETHYLENE - 1, 1'-BIS- (1. - METHYLPYRROLIDINIUM BITARTRATE)

PROP. - ANSOLYSEN (Wyeth)

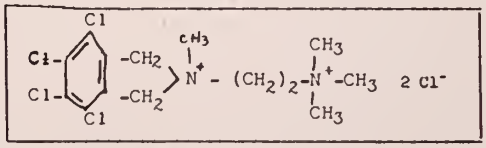


DESCRIP. - SYMMETRICAL 5 CARBON bis- QUATERNARY AMMONIUM CMPD.

CHLORISONDAMINE CHLORIDE (SU 3088)

CHEM. - 4, 5, 6, 7 - TETRACHLORO -2- (2-DIMETHYLAMINOETHYLISOINDOLINE DIMETHOCHLORIDE)

PROP. - ECOLID (CIBA)

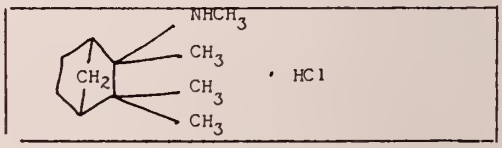


DESCRIP. - UNSYMMETRICAL QUATERNARY AMMONIUM CMPD.

MECAMYLAMINE HYDROCHLORIDE

CHEM. - 3-METHYLAMINOISOCAMPHANE HYDROCHLORIDE

PROP. - INVERSINE (SHARP & DOHME - MERCK)



DESCRIP. - SECONDARY AMINE (ONLY ONE NOT A QUATERNARY AMMONIUM)

Fig. 2. — Description of clinically available ganglionic blocking agents.

mg. periodically. Mecamylamine (Inversine) has the advantage of being almost completely absorbed from the gastrointestinal tract so that variation in bowel function does not change the extent of its absorption and consequently its therapeutic hypotensive effect. It is available commercially in 2.5 and 10 mg. tablets. For investigative purposes the manufacturer distributed 5 and 10 mg. slotted tablets. Its initial trial dose is 2.5 mg. given twice a day after lunch and at bedtime. It is increased by 2.5 mg. per dose as frequently as deemed necessary. Its duration of action is 12 to 24 hours. It is hoped the overlapping dosage will make for a smoother therapeutic result. The morning dose is avoided or decreased in order to prevent too great a drop in blood pressure because of the increased hypotensive responsiveness that occurs at that time.

Precautions

This type of potent medication necessitates certain precautions in order to avoid an excessive exaggeration of the expected orthostatic hypotension. As pointed out, the patient is particularly susceptible to a drop in blood pressure in the morning; consequently, the dose at that time should be smaller.

A low salt diet, mercurial diuresis, excessive perspiration and exercise exaggerate the hypotension. Consequently, it is usually preferable not to limit salt intake too rigidly. Mercury shots are given only when absolutely necessary. The effects of perspiration and exercise present a greater problem during the summer months in a warm humid climate such as Miami. In fact, it has been suggested that the dosage be decreased in visitors from the North.[5] One of my patients experienced orthostatic dizziness whenever he played golf. On those days the dosage had to be decreased. Bathing or swimming, if immersion is up to the chin, completely counteracts the hypotensive action of these drugs.[6] Whether or not it has a clinical significance in bathers remains to be seen.

After a large meal uncompensated splanchnic dilatation causes a drop in the blood pressure. For the average patient, however, with the usual meal we have not found this to be a problem. An excessive alcohol intake may also be excessively hypotensive in patients of this type.

	HEXAMETHONIUM	PENTOLINIUM (ANSOLYSEN) (Wyeth)	CHLORISODAMINE (ECOLID) (Ciba)	MECAMYLAMINE (INVERSINE) (Sharpe & Dohme)
APPROXIMATE (ORAL) RELATIVE POTENCY	1	5	6-10	50
DOSAGE ORAL mg.	CHLORIDE			
Tablet Size	125 *250	20 * 40 * 100	25 * 50	2.5 * 10
Initial	125 q 4-6 h	20 q 8 h	25-50 q 12 h	2.5 q 12 h
Increment	125	30-40	25	2.5
Range 24 hr.	500-2000	60-1400	40-500	3-120
Duration of effect	6 hr.	6-8 hr.	12 hr.	12-24 hr.
PARENTERAL mg.	BROMIDE			
Mg./cc.	44.75	10	5	1 * 10
Initial	2.5 - 5 q 4-6 h	2.5-3.5 q 6 h	1 q 12 h	2.5
Increment	5-10	0.5	1	2.5
Range 24 hr.	5-1200	30-60	2-6	3-120
Duration of effect	4 hr.	4-6 hr.		12-24 hr.
RATIO Oral:Parenteral	10:1	10-20:1	15:1 12:1	1:1

Fig. 3. — Dosage, tablet size and duration of hypotensive effects of the currently available ganglionic blocking agents.

Small blood losses of 250 cc. such as might occur from a bleeding peptic ulcer can result in dangerous hypotension in the patient receiving a maintenance dose of a ganglionic blocking agent. This is due to the absence of a compensatory vasoconstriction.[7]

A given dose of insulin can result in a lower than usual blood sugar when ganglionic blocking agents are started in the treatment of a diabetic patient.[8] Furthermore, the characteristic signs and symptoms of insulin shock (anxiety, palpitation, hunger, diaphoresis and tachycardia) may be blocked by the drugs. This effect, therefore, can result in the precipitation of unrecognized insulin shock.

A decreased tolerance to anesthesia has been described.[8] This may well explain the sudden death that occurred in a patient with malignant hypertension immediately after an aortogram was made. She received a general anesthetic for the procedure without discontinuing the ganglionic blocking agent. Apparently, cardiac standstill and respiratory arrest resulted when she was moved from the table to the stretcher.

Side Effects

A major disadvantage of ganglionic blocking agents in the treatment of hypertension is the unpleasant side effects (fig. 4). Fortunately, interstitial pneumonia, which has been fatal in several cases receiving hexamethonium, has not occurred with the other newer agents.

Because of acetylcholine inhibition there is a decreased sweating and increased peripheral blood flow. These changes cause an elevated skin temperature, and during hot weather one might expect an increase in body temperature, a complication not recorded in our cases despite the climate. The pupils dilate, causing photophobia and blurring of vision. This particular feature has been especially bothersome with Ecolid therapy; however, it can be successfully counteracted by the instillation of a 1 to 2 per cent solution of pilocarpine in the eyes. It did offer one advantage in that it was a simple matter to visualize the eyegrounds in these patients. Dry mouth due to decreased salivation was commonly present. Because of the depression of motility and delay in gastric emptying, nausea and vomiting may occur, but are infrequent.

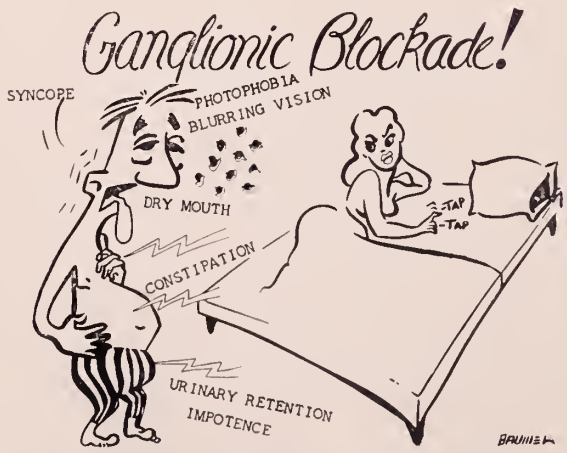


Fig. 4. — Undesirable side effects of ganglionic blocking agents.

The greatest difficulty has been with constipation due to a diminution of intestinal activity. This had been more severe with hexamethonium therapy. The precaution is taken of insisting upon bowel movements daily or every other day. Fifteen to 30 mg. of Prostigmin daily is occasionally prescribed, plus any suitable cathartic. With an enlarged prostate, urinary retention or delayed emptying of the urinary bladder may occur, but, fortunately, not frequently. Impotence, especially with the larger doses, has been a fretful complication, and some patients may refuse to take the drug because of this side effect. It can be overcome at times by omitting the appropriate dose.

The potentiation of the pressor effects of epinephrine or epinephrine-like drugs by a blockade of the compensatory reflexes which ordinarily oppose the rise may possibly explain the bursts of hypertension occasionally noted in the clinic despite a satisfactory therapeutic response recorded by home blood pressures. As one might expect, in the clinic the patients are frequently restless, nervous and apprehensive, often having to wait a long time for their examinations. This state theoretically induces excessive secretion of pressure-inducing substances, which are potentiated by the ganglionic blocking medication.

With an excessive drop in blood pressure, the collateral signs of shock, such as tachycardia and sweating, may be absent. It is remarkable that at times the orthostatic blood pressure may be well below 100 systolic without the patient having any subjective bad effects. Conversely, in other cases the patient complains of feeling poorly when the pressure is down only to therapeutic levels.

These drugs may have an adverse effect on the circulation through partially obstructed atherosclerotic vessels of the brain, heart, kidneys or peripheral arteries. One patient with intermittent

claudication of the lower extremities had an aggravation of his symptoms when the blood pressure was down to a reasonable level. That was his method of knowing when he had the desired therapeutic effect. This result is contrary to the augmentation of peripheral circulation that has been demonstrated.[9]

It should be pointed out that most of the side effects mentioned became less of a problem as the condition of the patients became stabilized on the medication.

Indications

In general the indication for ganglionic blocking agents in hypertension is severe essential hypertension with signs and symptoms of vascular damage as manifested by degenerative effects on the cerebral circulation, eyegrounds, heart or kidneys.

Intercerebral or subarachnoid hemorrhage in the presence of severe hypertension is an indication for maintaining the blood pressure at a lower level, thereby decreasing the risk of more bleeding. In the case of cerebral thrombosis it is advisable to delay lowering the blood pressure for a few months after the acute episode so that further thrombus formation is not encouraged.

Hypertensive encephalopathy responds dramatically when the pressure is lowered; however, at this time periodic injections of 2.5 to 5 mg. of reserpine seem to be the treatment of choice. This therapy avoids the hazards of excessive hypotension.

Grade III or IV hypertensive retinopathy according to the classification of Keith, Wagener and Barker[10] is an urgent indication for hypotensive therapy because of the poor prognosis such patients have without treatment.

Congestive heart failure caused by hypertensive cardiovascular disease is helped by lowering of the diastolic pressure with ganglionic blockade. Renal disease, manifested primarily by albuminuria in hypertensive patients, with progressive impairment of function is reason enough to lower the blood pressure. It is hoped that the renal function may be improved after instituting therapy with the ganglionic blocking agents. This end is not often achieved. Finally, a patient with a fixed high diastolic blood pressure of over 120 mm. of mercury is a definite candidate for this medication.

When one uses agents as potent as these, it is essential to keep in mind the objective of helping the patient. Corcoran, Dustan, Taylor and Page[11] considered this when they stated two counterbalancing axioms: first, "above all do no harm," and secondly, "disease should be countered in its incipiency, since to delay too long may be to treat too late." Indeed, an elevated blood pressure tends to be self-perpetuating. Schroeder[8] suggested that the reverse may also be true. In other words, he gave evidence that the process of hypertension may reverse itself, if a drug-induced normal or approximately normal tension is maintained for a long enough period of time.

It has been demonstrated that hypertensive patients with cerebral or renal complications have a 10 year mortality of 80 per cent. Without such complications it is only 20 per cent.[12] These figures offer further evidence that the elevated pressure should be lowered before degenerative changes occur.

Contraindications

The contraindications are only relative. Nevertheless, when they are present, one must weigh them against the benefits of a lowered blood pressure, and at the same time consider the hazards inherent in the hypertension. Usually, these contraindications can be ameliorated by specific counter measures.

A blood nonprotein nitrogen over 60 mg. has been recommended as a contraindication because the precipitous drop in blood pressure decreases renal blood flow and accelerates the renal failure. In an occasional case of malignant hypertension with impending uremia, however, salvage does occur. It may be that at least part of the azotemia is on the basis of a coexisting congestive heart failure which is relieved by the drop in blood pressure produced by the ganglionic blocking agent. In any case, it has been shown to have no demonstrable deleterious effect in patients showing no evidence of renal impairment prior to therapy.[13]

Drying of bronchial secretions by the blocking agents in pulmonary disease may be harmful in some cases. Usually, however, the hypertension is considered as the greater hazard.

In the presence of prostatic hypertrophy, urinary retention can occur. Although we have encountered some patients who had difficulty in starting the urinary stream, none of them have experienced actual retention requiring catheterization.

Borderline glaucoma may be precipitated by the use of these agents, as has occurred in one case known to us. With proper precautions

and appropriate therapy, it should present no problem. In organic pyloric stenosis, the obstruction can become complete.[12] We are unaware of any such cases. When recent vascular thrombosis has occurred, whether cerebral, coronary or peripheral, six weeks should elapse before initiating therapy with ganglionic blocking agents.[13]

In the presence of a pheochromocytoma, secretions of epinephrine or norepinephrine may be provoked. Their occurrence is especially hazardous because their action is potentiated by ganglionic blocking agents.[14]

Results of Therapy

The results of therapy in the clinic are currently being evaluated. Certain tentative statements may be made at this time.

In a small minority of patients the hypertension was especially difficult to control by these agents. In one patient in particular it could not be controlled by Ansolysen, Ecolid or Inversine; however, the pressure was maintained satisfactorily at a lower level with the addition of hydralazine.

As frequently pointed out, it soon became apparent that home blood pressures were necessary in order to develop a satisfactory regimen.[14, 15]. Levels determined in the office or clinic frequently ran much higher than those recorded at home and could result in overdosage with symptoms of syncope and dizziness. Trained visiting nurses take frequent home blood pressure readings on clinic patients, and they are brought to the attention of the clinicians. Private patients are taught to take their own blood pressure or have someone in the family record it. The latter method has been a particularly successful procedure. Both have added a great deal in regulating the dosage and in preventing adverse side effects.

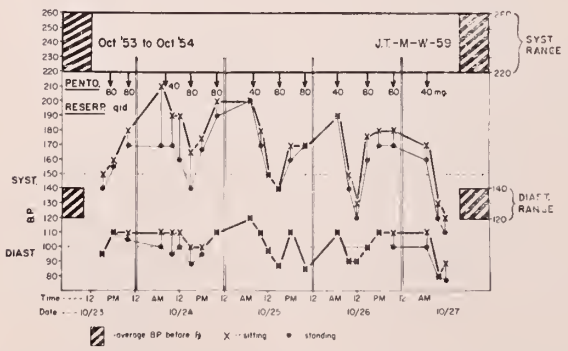


Fig. 5. — Satisfactory response in a severe case of hypertension (220-260/120-140) to oral pentolinium therapy.

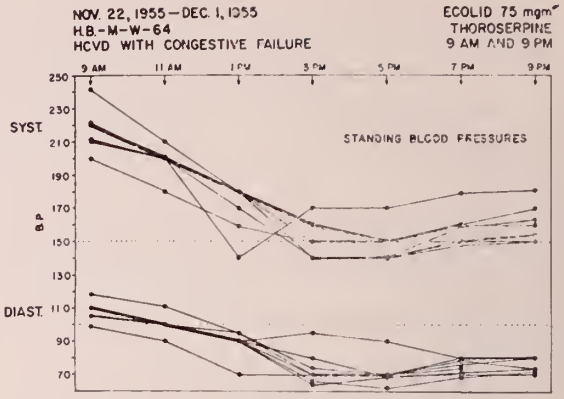


Fig. 6. — Superimposition of multiple standing blood pressure readings on six consecutive days, patient receiving Thoroserpine and 75 mg. of Ecolid at 12 hour intervals.

Figure 5 demonstrates the lowering of the blood pressure in a patient who had a "stroke" a few years earlier. It shows the great variation in the blood pressure level under the influence of medication.

In figure 6, six days of therapy with Ecolid are superimposed showing the characteristic elevated early morning blood pressure. It demonstrates the relative uniformity from day to day.

By far the most dramatic therapeutic results occur in cases of malignant hypertension and congestive failure due to hypertensive cardiovascular disease. In both there is a decided improvement in the prognosis and a definite decrease in the disability of the patient. The grade IV hypertensive retinopathy changes to grade III or II, the patient often returning to a gainful occupation.

Keith and his associates[10] showed that in cases of malignant hypertension there is a four year survival rate of 2 per cent. Corcoran, Page, Dustan and Lewis[16] demonstrated a four year survival rate of 25 per cent and stated that it is probably more likely 40 per cent with the use of the newer hypertensive agents. Patients with congestive heart failure requiring mercurial diuresis two to three times a week have remained free of congestive failure with only digitalis therapy for many months. In addition, the improvement has been manifested by a decrease in the size of the heart, noted on roentgen studies and fluoroscopy, and by a reversal of the strain pattern in the electrocardiogram. Many patients seem to have less angina on effort. A progressive decrease in renal function has been halted and even reversed.

Summary

Ganglionic blocking agents are effective and practical in the treatment of complicated severe

essential hypertension. The mode of action, different agents available, precautions, side effects, indications, contraindications, and results of therapy are briefly discussed.

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Surgical Dysphagia

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The symptom dysphagia implies a difficulty in swallowing. Whether or not one should subdivide dysphagia into medical and surgical categories is debatable. It is my purpose to discuss some of the more common causes of dysphagia which are amenable to surgical therapy as distinct from such medical problems as tetanus, myasthenia gravis, bulbar paralysis and other purely medical conditions which cause dysphagia.

Many diseases affecting the esophagus are insidious and may readily be overlooked in their early stages. Dysphagia is certainly not always the presenting symptom or indeed constant. It should, however, lead one to suspect certain pathologic conditions in the esophagus and should be the cause for further studies. Boyd[1] strongly suggested that every patient with dysphagia should have repeated studies before this difficulty is labeled functional. Fry and Putney[2] emphasized the importance of dysphagia as one of the first symptoms of esophageal disease.

Anatomic and Physiologic Considerations

Anatomically the esophagus is approximately 23 to 25 cm. in length. It is a muscular canal extending from the pharynx to the stomach. According to Gray,[3] it begins at the lower border of the cricoid cartilage opposite the sixth cervical vertebra where it is continuous with the lower end of the pharynx. It descends along the front of the vertebral column through the superior and posterior parts of the mediastinum, pierces the diaphragm opposite the tenth dorsal vertebra and ends at the cardiac orifice of the stomach at the level of the eleventh dorsal vertebra.

The general direction of the esophagus is vertical, but it presents two slight curves in its course, both of which are to the left. One is at the root of the neck, and the other is as it passes through the diaphragm. It is the narrowest part of the alimentary canal and is constricted at three points: (1) at its commencement, (2) at the hilus where it is crossed by the left bronchus, and (3) where it pierces the diaphragm. As will be seen later, obstruction occurs readily at these three points.

An applied anatomic feature is the absence of the longitudinal muscle fibers in the upper posterior part of the esophagus just below the cricoid cartilage. Here the fibers diverge from the midline leaving a V-shaped defect which is covered only by the circular muscle fibers. The mucous membrane of the esophagus may herniate through this area to form a diverticulum.

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The act of swallowing, according to Best and Taylor,[4] is divided into three stages: (1) The first stage is under voluntary control, the bolus of food being propelled by the back of the tongue into the pharynx. A pressure of some 20 cm. of water is developed in the posterior part of the mouth, pharynx and upper portion of the esophagus. (2) The second stage is brief and is occupied in guiding the food through the pharynx and past the openings that lead from it. Once it is in the pharynx, the constrictors contract, and so the bolus is forced into the esophagus. It is prevented from passing back into the mouth by the continued pressure of the base of the tongue, which initiated the first stage. Similarly, the opening into the nasopharynx is closed by the muscles which raise the soft palate. The bolus is prevented from entering the larynx by the thyrohyoid muscle, which actually elevates the larynx. Thus when the larynx is fixed and unable to rise, swallowing is difficult or impossible. The vocal cords close at the time the larynx rises and so aid swallowing. (3) The third stage involves the passage of food down the esophagus. Peristaltic waves carry the food down into the stomach. The cardiac sphincter, which remains tonically closed at all other times, relaxes when the bolus reaches it and so allows the food to enter the stomach. It takes six to seven seconds for solids and semisolids to pass from the mouth to the stomach.

The swallowing of liquids is slightly different in that they are not carried down by a peristaltic wave, but precipitate with great rapidity to the lower end of the esophagus. The cardiac sphincter under such circumstances does not immediately relax, but waits until a peristaltic wave arrives a few seconds later. In these precious few seconds a caustic corrosive can do untold damage. Daly[5] found the severest corrosive burns at the cardia and the midesophagus.

The cardioesophageal mechanism has been the subject of much discussion, and opinions are divided as to the presence or absence of a sphincter mechanism at the cardioesophageal junction. One is concerned with this mechanism in trying to explain the delay in the entry of esophageal contents into the stomach, and also to explain regurgitation of the acid gastric contents into the esophagus. The work of Allison[6] on sliding hiatus hernia causing esophagitis has stimulated much of this discussion.

Marchand[7] has shown that a physiologic delay in the passage of food from the esophagus to the stomach occurs on deep inspiration and during the Valsalva test. He accounted for this delay by the differences in pressure between the thoracic and abdominal cavities. It is never more than temporary. The pathologic delay in achalasia and lye injury is due to failure of relaxation of the terminal portion of the esophagus.

As the intraperitoneal pressure is greater than the intrapleural pressure, a mechanism must be present to prevent the continuous regurgitation of stomach contents into the esophagus. It is thought that the diaphragm and right crus of the diaphragm play no part in this mechanism, but rather that it is the oblique angle at which the esophagus enters the stomach and the resting tone of the terminal portion of the esophagus which prevent this regurgitation. Reflux occurs only during inspiration. It has been postulated that the lax gastric mucosa in the region of the cardia acts as a valve.[8]

Dysphagia is a symptom complex encountered in all age groups from the newborn infant to the geriatic patient. Some of its more common causes are listed in tables 1 and 2.

Table 1. — Local Causes of Dysphagia in the Alimentary Canal[17]

A. All acute and painful:
1. Acute inflammation in the floor of the mouth or pharynx
2. Acute esophagitis
3. Corrosion
4. Foreign body
5. Peptic ulcer
6. Congenital anomalies

B. Chronic and usually painless:
1. Cardiospasm
2. Simple stricture
3. Pharyngeal pouch
4. Carcinoma of the esophagus, pharynx, larynx or cardia

Table 2. — Local Causes of Dysphagia Outside the Alimentary Canal[17]

A. All acute and painful:
1. Acute submandibular sialadenitis
2. Acute cellulitis of the neck
3. Acute cervical lymphadenitis
4. Acute suppurative pericarditis
5. Acute mediastinitis
6. Acute thyroiditis

B. Chronic and painless:
1. Malignant disease of cervical lymph nodes
2. Carcinoma of the thyroid
3. Malignant deposits in the mediastinal glands
4. Mediastinal tumor
5. Aneurysm of the aorta
6. Congenital vascular anomalies
7. Retrosternal goiter
8. Vagotomy

Congenital Anomalies

In the newborn the most common cause of dysphagia is atresia of the esophagus with or

without a tracheoesophageal fistula. Other congenital anomalies are: (1) Absence of the esophagus is a rare condition and not compatible with life. (2) Congenital web is likewise a rare condition, and treatment consists merely of dilatation. (3) Chalasia is a state of relaxation of the cardia. Probably there is some neuromuscular imbalance. Vomiting during the first few days of life is common, and diagnosis can be made by roentgen examination. Treatment is not surgical, but feeding the infant in a sitting position and maintaining this position for 45 minutes after each feeding. Spontaneous cure eventually results.

Atresia. — Over 90 per cent of cases of atresia with associated tracheoesophageal fistula are of the variety in which the upper esophageal pouch ends blindly at the level of the third and fourth thoracic vertebrae, and the lower esophageal segment communicates with the trachea. The distance between the proximal and distal segments of the esophagus varies and is a most important fact in the surgical correction of this condition.

The diagnosis can readily be made within a few hours of birth, if suspected. Excessive salivation is prominent, and while the infant appears to be hungry and to take the bottle, it immediately regurgitates on swallowing. Cyanosis and paroxysmal coughing also occur.

The diagnosis can be confirmed simply by passing a soft No. 10 rubber catheter down the esophagus. If atresia is present, an impassable obstruction will be encountered. Further confirmation by using 1 to 2 cc. of lipiodol will show a blind pouch on roentgen examination. A lateral view may demonstrate a fistula. Roentgen study of the abdomen is of diagnostic value. The absence of air in the stomach will imply no fistulous communication between the lower esophageal segment and the trachea, whereas the presence of air in the stomach indicates fistula formation. This latter is the more common condition.

A word of warning should be given regarding the use of barium in infants with atresia. Aspiration of barium may cause a fatal pneumonitis; so it should never be used.

Untreated, these infants will die within a few days. Aspiration pneumonia, inanition and the reflux of gastric contents into the tracheobronchial tree all contribute to the fatal outcome. Treated with surgery, a large percentage can be saved. It was not until 1942 that Haight[9] performed the first successful operation for tracheoesophageal fistula. Since then numerous successful cases have been recorded.

Preoperative preparation is a most important adjunct to surgery and should include antibiotics, careful suctioning, postural drainage and parenteral fluids. It is, however, much easier to overhydrate these infants than to dehydrate; so great care must be used, and not more than 20 cc. per pound in a 24 hour period should be given.

Originally, multiple stage retropleural procedures were carried out to correct this anomaly. Today, the one stage procedure is almost universally used. The right transpleural approach is quicker and easier than the retropleural approach and certainly no more shocking to the infant. The proximal and distal ends of the esophagus are identified, the fistula divided and the opening in the trachea closed. A primary end to end esophageal anastomosis is then performed. Occasionally the distal segment is too short, but in cases of this type the stomach can be freed around the hiatus and readily pulled up into the chest for anastomosis.[10]

Although not essential, it is safer to perform an immediate feeding gastrostomy rather than run the risk of early feeding or irritation of the anastomotic line by an indwelling polyethylene catheter.

Unfortunately the incidence of complications is fairly high.[11] Postoperatively, pulmonary complications and those associated with the actual anastomosis are the most common. Recurrence of the fistula, a cutaneous fistula following leakage, disruption of the anastomosis and, finally, stricture formation, all occur.

Anomalies in Children

In the older infant and the child there are different causes of dysphagia. Such anomalies as congenital stenosis, congenitally short esophagus and duplication of the esophagus may not become evident until the child begins to take solid foods. Usually periodic dilatations will effect a cure in cases of congenital esophageal stenosis.

There are several vascular anomalies which produce dysphagia in the young child. Usually there is some associated respiratory distress as both the trachea and the esophagus are compressed. The most common anomalies are: (1) Double aortic arch. (2) Right aortic arch with left ligamentum arteriosum. (3) Aberrant subclavian artery. Usually the subclavian is a branch of the innominate artery, but occasionally it will arise from the aortic arch and in its course to the right pass between the vertebral column and the esoph-

agus. Compression of the esophagus gives rise to dysphagia lusoria.

Diagnosis of these vascular anomalies is by roentgen studies, and the treatment is division of the compressing ring or vessel.

Stricture following anastomosis for congenital atresia can likewise often be cured by dilatations, especially if occurring several months postoperatively.

LYE BURNS. — Stricture formation following the lye burn is the most distressing form of dysphagia which one sees in the young child. Too often it is the story of the careless parents leaving lye exposed to the child in an open soft drink bottle. Holinger and Johnson[12] stated that, once the esophagus is burned, stricture formation may occur at any time in the life of the patient.

Following ingestion of the lye, burns around the mouth, tongue and pharynx are frequent, but usually not so severe as at first appears. It is in the esophagus that the damage is the greatest, and usually most extensive. Once the lye reaches the stomach, it is fairly rapidly neutralized, and little burn damage results to the stomach itself.

Belinoff[13] divided the corrosive lesions into four stages:

(1) Necrosis which occurs during the first week
(2) Ulceration which occurs during the second week
(3) Granulation tissue formation occurring in the third week
(4) Scar formation which begins in the fourth week

The immediate treatment of the lye burn is symptomatic. Attempts at neutralization are useless unless they can be applied immediately. After but a few minutes coagulation necrosis is occurring. Gastric lavage is dangerous because of the possibility of perforation of the esophagus. Supportive therapy with sedation, antibiotics, tetanus toxoid or antitetanic serum is all one can use in the early hours of a lye burn. Frequent sips of olive oil may be soothing.

It is sometimes difficult to be sure whether actual damage to the esophagus has occurred. In such cases, and in fact in all cases of lye burn, esophagoscopy, if necessary under anesthesia, can be performed provided the esophagoscope is not passed through the burned area. This precaution eliminates the danger of perforation.

After the acute state, which may last several days, the problem to be faced is that of stricture formation. Daly[5] advocated early dilatation with mercury-filled bougies. These bougies are passed every 24 hours commencing on the fourth or fifth day. In adults the size of the bougie is increased until a No. 40 French dilator can be passed, and in children a No. 30 French dilator, or larger. The largest bougie passed is left in place for at least 20 minutes. These dilatations are continued for about one month, and then at intervals depending on the degree of dysphagia. A lumen through which a No. 40 French dilator can be passed is considered to be of good size.

If damage to the esophagus has been extensive and subsequent stricture formation severe, after three to four weeks it may not be possible to pass the mercury-filled bougie. In such cases a weighted string should be passed and a Witzel type feeding gastrostomy established. Then weekly retrograde dilatations are carried out. This is by far the safest method in the extensive stricture, as attempted dilatation from above may perforate the esophagus and cause a fatal mediastinitis.

What should be done in the case of the impassable stricture? Should an attempt at resection be performed? Should an antethoracic procedure with a prosthesis or loop of jejunum be used to create a passage for food? Or should a Roux-Y type esophagojejunostomy, as used for malignant disease, be performed through a thoracoabdominal approach? And finally, should the diseased segment of esophagus be removed, or left in situ as a blind sac with the possibility of future cyst formation?

I do not believe one can answer these questions accurately as no adequate series of cases has been reported claiming success for any one method, except possibly the series of Yudin,[14] who performed an extrathoracic esophagojejunostomy. Most of Yudin's cases, however, were in adults.

I think that conservatism is indicated in treating the child, and provided good nutrition can be maintained with a feeding gastrostomy, this method should be continued indefinitely. Periodic retrograde dilatations should be carried out, and when the adult stage is reached, an elective procedure may possibly be more safely performed.

Dysphasia in Adults

In the adult the more common causes of dysphagia are: achalasia, tumors either benign or malignant, strictures from lye burns or peptic esophagitis, extrinsic pressure from thyroid enlargement, cellulitis of the neck as in Ludwig's angina, and mediastinal nodes. Bronchogenic

carcinoma, esophageal diverticula and foreign bodies are also causes of dysphagia.

It is difficult to break these diseases down for various age groups, but essentially carcinoma and diverticula occur in the older patient, whereas the other conditions occur in the younger adults. Achalasia is observed mainly in the age group of 20 to 40 years, with about an equal distribution between the sexes.

Achalasia. — The term cardiospasm is used synonymously with achalasia. Although the etiology remains uncertain, it is thought that there is some derangement of the ganglia of Auerbach's plexus which prevents relaxation of the lower segment of the esophagus. This is similar to Hirschsprung's disease in the lower portion of the colon. Concomitant hypertrophy of the muscle layers of the lower segment of the esophagus occurs. Proximally there is dilatation of the esophagus, and radiologically a rounded termination of the esophagus at the cardia can be seen. The differential diagnosis from carcinoma is not difficult, as in carcinoma the outline of the lower segment of the esophagus is irregular and usually there is little proximal dilatation.

Although carcinoma of the esophagus rarely occurs as a complication of achalasia, Groves[15] reported two cases. It is noteworthy that in one of these cases, endoscopy was performed, but the carcinoma was missed because of the wide esophageal lumen which was not adequately washed out. Thus, careful esophagoscopic follow-up of patients with known achalasia should be carried out.

The diagnosis of achalasia depends on barium studies following recognition of the symptoms — dysphagia, epigastric and substernal discomfort, and regurgitation of foods eaten several hours previously. Frequently patients will complain of a substernal sticking sensation.

In the majority of cases there will be response to one or more periodic dilatations with mercury-filled bougies. Numerous other methods of dilatation have been advocated, including the use of a pneumatic dilator.

In those cases in which there is no response, or in which adequate prolonged relief is not obtained by dilatation, some surgical procedure is required. Here again, numerous operations have been devised, all focusing on the spastic segment of the lower portion of the esophagus. Resection of this segment and its by-passing with an esophagogastrostomy have both been performed. Postoperative reflux peptic esophagitis frequently occurs. Vagotomy has been tried but discarded because of the poor results.

The simplest and best procedure is that described by Heller[16] in which an esophagocardiomyotomy is performed similar to the principle of the Fredet-Ramstedt pyloromyotomy for pyloric stenosis. A thoracoabdominal or an upper abdominal approach can be used. In the abdominal approach, division of the triangular ligament with retraction of the left lobe of the liver gives perfect exposure of the esophagogastric junction. Whichever approach is used, one makes a longitudinal incision through the muscular coats of the esophagus and adjacent cardia down to the mucosa, being sure that the incision is carried sufficiently far proximally on the esophagus and distally on the cardia. Aird[17] claimed immediate and dramatic relief of the dysphagia in 80 to 90 per cent of cases.

Benign and Malignant Tumors. — Benign tumors of the esophagus are exceedingly rare, and obstruction is most likely to occur if the tumor obtains sufficient size.[18] Surgical removal of these tumors gives excellent results.

Dysphagia is not a prominent symptom of the benign tumor, but is the commonest symptom of the malignant tumor of the esophagus. At first it may be intermittent, but later it is always progressive. Other symptoms which may be present are retrosternal or interscapular discomfort and epigastric distress.

Although occurring at any level, carcinoma of the esophagus is most common at the points of physiologic narrowing, namely at its commencement, at the hilus and at the cardia. The slightest suspicion of difficulty in swallowing in an otherwise healthy adult, especially if over 40 years of age, should lead to a careful examination for cervical nodes or intraoral pathologic change. A barium swallow study must next be obtained. The radiologic diagnosis depends on the finding of some irregularity of the esophageal wall and narrowing of its lumen. Proximal dilatation is not so frequently seen as in the benign lesions of the esophagus. Following barium studies, esophagoscopy with biopsies must be performed.

Adams[19] considered the trend of pessimism towards surgical treatment of carcinoma of the esophagus to be one of the greatest detriments to progress in the surgical treatment of this tumor. This observation is no doubt true because by the time the diagnosis is made, resection is often impossible. Unfortunately, it may be the case by the time dysphagia occurs. Resection of the lesion and regional nodes with an esophagogastric anastomosis is, however, the treatment of choice for

growths in the cardia and lower thoracic portion of the esophagus. For apparently curable lesions in the midthoracic segment of the esophagus, resection with anastomosis is probably best.[20] For more advanced lesions, an indwelling polyethylene tube or local resection with insertion of a polyethylene tube as advocated by Berman,[21] or alternatively radiotherapy may have at least as strong a palliative effect. In the upper thoracic segment of the esophagus and in the cervical portion of the esophagus, surgical removal is more difficult, and it may be that roentgen therapy offers the best palliation in this area.

EXTRINSIC LESIONS. — Extrinsic lesions such as Ludwig's angina and thyroid enlargement are infrequent causes of dysphagia. With the advent of antibiotics, Ludwig's angina is rarely encountered. Often it followed tooth extractions and consisted of a severe cellulitis with pus formation beneath the deep cervical fascia of the neck. Brawny induration of the neck, dysphagia, dyspnea, and the tongue pushed up by edema were classical findings. Incision and drainage were life-saving. The thyroid carcinoma or adenoma may on occasion be present with dysphagia due to esophageal compression. Careful examination of the neck with lateral roentgenograms will aid in the diagnosis. A carcinoma of the lung may produce anterior displacement of the esophagus with narrowing of the lumen and dysphagia.[22]

FOREIGN BODIES. — The foreign body may be another insidious cause of dysphagia. A history of recently ingested foreign body presents no difficulty in the diagnosis. Increasing dysphagia, however, with no history of ingested foreign body is somewhat different, and often carcinoma is suspected. Roentgen studies with barium will prove the presence of an obstruction. Esophagoscopic examination will reveal the obstructing foreign body.

ESOPHAGEAL DIVERTICULA. — Esophageal diverticula are of several varieties. They occur typically in three regions: (1) at the pharyngoesophageal junction; (2) in the midesophagus; and (3) just above the cardia. By far the most common variety is the pharyngoesophageal diverticulum, or pharyngeal pouch. It consists of a protrusion of mucosa through a weak spot in the musculature of the inferior constrictors at the junction of the pharynx and the esophagus. Predisposing causes of diverticulum are the narrowing of the pharynx at this level, the fixed nonstretching anterior laryngeal wall, and the water-hammer effect of sudden increase of intrapharyngeal pressure during deglutition, often up to 25 cm. of water.[23] This type of diverticulum is known as a pulsion diverticulum as distinct from the traction variety found in the midesophagus. Here inflammation and fibrosis, usually in a node, will pull out all layers of the esophagus to form a diverticulum. It seldom produces symptoms, but occasionally may cause dysphagia.

The rare epiphrenic diverticula are of the pulsion variety and occur 3 to 4 inches above the cardia, more commonly on the right posterior esophageal wall. Pain and dysphagia may occur.

The mechanism by which the pharyngoesophageal diverticulum causes dysphagia is by angulation and finally obstruction of the esophagus by the dependent food-filled sac which descends between the esophagus and the vertebral column, usually on the left side. Regurgitation of the contents of the diverticulum is another distressing symptom, especially if it occurs while the patient is asleep and the spill-over into the pharynx causes choking and coughing. Gurgling sensations in the sac are another symptom. Diagnosis is confirmed by barium studies which show a smooth-contoured pouch which is always single.

Treatment of the pharyngoesophageal variety of diverticulum is by excision. Although Lahey[24] strongly supported the two stage procedure because of the dangers of mediastinitis and the low mortality, it is safe with antibiotics to perform a one stage diverticulectomy through an oblique incision in the left side of the neck anterior to the sternocleidomastoid muscle. According to Sweet,[25] the one stage procedure is simpler, has fewer complications, requires less hospitalization, and gives complete and permanent results. Surgical treatment of the other types of diverticula is rarely indicated.

OTHER LESIONS. — Ulceration of the lower segment of the esophagus with subsequent stricture formation may occur as a result of the reflux of acid gastric contents through an incompetent cardioesophageal junction. The cause of this incompetency is usually a sliding hiatus hernia. Stewart, Chardack and Alfano[26] found this to be the case in 42 of their series of 66 cases of peptic esophagitis. Other causes are ectopic gastric mucosa and postoperative interference with the esophagocardial junction such as follows resection, or short-circuiting of the terminal portion of the esophagus.

Esophagitis may cause dysphagia and substernal and interscapular discomfort. Vomiting

may occur, depending on the degree of stenosis.

The treatment of the hiatal hernia with mild symptoms is medical. Surgery with repair of the defect should be performed in the larger hernias with symptoms. When there is stenosis, dilatation should first be attempted. Failing this, resection of the involved segment with esophagojejunostomy or esophagogastrostomy should be performed. Results of surgical treatment are equivocal, and recurrent esophagitis occurs even following esophagojejunostomy.

Summary

Dysphagia is often the presenting symptom in surgical conditions affecting the esophagus.

Every patient with dysphagia, whether a newborn infant or a geriatric problem, should be examined carefully at the outset to find the underlying cause, as early diagnosis and treatment are often life-saving.

The diagnosis can usually be made on the history, but confirmatory roentgen studies, esophagoscopy and biopsies may be required.

The treatment of surgical dysphagia is as varied as its causes. These include congenital anomalies, strictures from lye burns or peptic esophagitis, achalasia, tumors both benign and malignant, esophageal diverticula, foreign bodies and extrinsic lesions affecting the cervical and mediastinal structures.

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Discussion

Dr. DeWitt C. Daughtry, Miami: Dr. Gould is to be complimented for his excellent discussion of an important topic. It was impossible in the time allotted him to discuss or properly emphasize every important aspect of dysphagia.

In my association with large hospitals during 18 to 20 years, corrosive injuries and their sequelae have proved the greatest single problem in this field. Most of these have been in children and due to accidental ingestion of corrosives, usually lye, but occasionally in adults with suicidal intent. It is may policy to feed them parenterally for several days and have them swallow a silk thread for subsequent dilatation purposes in the event dilatation becomes necessary. Esophagoscopy at 10 to 14 days reveals whether the superficial burns have healed, making no further treatment necessary, or whether there are extensive deep burns demonstrated by granulation tissue. If the latter condition is present, dilatations must be started immediately to help prevent stricture formation. X-ray studies are unreliable in determining the extent of damage. The place of adrenal corticosteroid therapy in minimizing stricture formation has not been determined at this time.

Carcinoma of the esophagus is common and has a poor prognosis. It is doubtful whether surgery should be used for the malignant lesions of the upper one third of the esophagus, because prognosis is so very poor. In fact, I do not have a single five year cure following resection for malignant disease of the esophagus at any level. At the present time I am experimenting with a new type of plastic prosthesis which can be introduced in a simple manner without surgery when excision is not feasible. If this technic can be perfected, it will be a therapeutic measure of considerable palliative value.

Early diagnosis and surgery are the best keynotes to success in the congenital tracheoesophageal fistula and stenosis problems. Excessive salivation should lead to the diagnosis before the first feeding.

Esophagomyotomy is not necessary in all cases of achalasia. Many will respond to proper dilatation, especially in the younger age group. I have seen it succeed when major surgical procedures have failed.

Pulsion diverticula of the hypopharynx and esophagus are not uncommon and are usually considered surgical lesions. They may obstruct the esophagus, and I have recently seen a 50 per cent reduction in weight in two patients due to starvation. In such cases it is necessary to perform gastrostomy or introduce a feeding tube through the esophagoscope for preoperative preparation. The latter is preferred and has been successful in my hands.

Diaphragmatic hernia may produce dysphagia and actually obstruct the esophagus. I have seen two cases in which acute and practically complete obstruction occurred due to torsion of the herniated stomach. In one the stomach became gangrenous and perforated into the left pleural cavity.

Peptic esophagitis and associated stricture formation are common and can usually be treated successfully medically and by esophageal dilatation. Occasionally major surgical attack is necessary. Gastroduodenal ulceration and gallbladder disease may produce dysphagia and actually obstructing spasm of the lower portion of the esophagus.

Foreign bodies and spontaneous and traumatic perforation of the esophagus dictate prompt and obviously specific surgical attack. Upper abdominal and/or lower thoracic pain and shock following violent vomiting should promptly lead one to an immediate diagnosis of spontaneous perforation of the esophagus. This is an extreme surgical emergency.

A variety of other lesions produce dysphagia. Ulcerating carcinoma of the larynx or pharynx may produce a most painful dysphagia. Congenital vascular rings may produce dysphagia at an early age, and death may ensue from tracheal obstruction. Benign congenital cyst, congenital webs and nonmalignant tumors are rare causes of dysphagia, but are favorable surgical lesions. Tumors of the mediastinum may produce dysphagia, and one should be aware of the aortic aneurysm which may involve the esophagus and mimic a tumor. I have had one such case in a physician in which the aneurysm perforated into the esophagus while the cause of dysphagia was being investigated.

Neurologic lesions may be responsible for dysphagia. I have seen several recent cases due to vocal cord paralysis, multiple sclerosis, poliomyelitis and idiopathic localized nerve palsy. Dysphagia associated with scleroderma has been encountered.

Do not forget that lesions of the upper part of the abdomen such as tumors of the upper portion of the stomach and retroperitoneal area may produce dysphagia.

Finally, I would like to stress the great importance of the use of the esophagoscope in the investigation of dysphagia and in many other symptoms of esophageal disease. Tumors, ulceration, congenital defects, and foreign bodies may be totally unsuspected after repeated x-ray studies of the esophagus, but be obvious by esophagoscopic examination.

Again, I wish to thank Dr. Gould for presenting this timely topic to our Association.

Pelvic Pain

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Pain impulses from pelvic viscera course through the somatic afferent nerve fibers, called the visceropelvic nerves. They pass upward in the sympathetic chain to the spinal cord at the proper level stations. Here the impulses are sorted out, and with the "visceromotor" reflex the person is aware of the general location of the origin of the impulse. The vagueness of localization of pelvic pain is thought to be due to the minute size of the sensory nerves. In some persons pelvic pain may arise, not from the pelvic organs, but from abdominal wall sites, either anterior, lateral, or posterior in the skeletal back. Genital sites may sometimes cause low back pain, but rarely do skeletal origins cause pelvic pain. Guerriero and Stuart[1] presented an excellent review of the basic anatomy and physiology concerned with gynecologic pain, and pain which simulates it. The area involved usually is below a line drawn from each of the anterior iliac spines to the umbilicus and may involve the vulva or the inner aspect of the thighs extending about one third of the distance to the knees. These areas are identical with the area of pain to which labor pains and dysmenorrhea are referred. The first lumbar nerve supplies this area, and the visceromotor reflex is the modus operandi. The character of the pain may be acute or chronic. The acute type resembles angiospasm or hypercontraction of muscle. The chronic pelvic pain suggests congestion.

Read before the Florida Obstetric and Gynecologic Society, Ninth Annual Meeting, Miami Beach, May 13, 1956.

Characteristics of Acute Pelvic Pain

The symptoms may be:

1. Severe, colicky, indefinite, or generalized pelvic pain.
2. Associated with nausea and vomiting (considered a reflex symptom).
3. Associated with constipation or obstipation.
4. Symptoms of ectopic pregnancy, ruptured or leaking (peritoneal irritation).
5. Mittelschmerz with spotting.
6. Dysmenorrhea.
7. Dyspareunia.

Findings or physical signs:

1. Lower abdominal tenderness.
2. Rarely muscle spasm (except with peritoneal irritation).
3. If coinciding with ovulation, the findings are slight.
4. If associated with menstruation, the pain is often acute and muscle spasm may be present, but is usually indefinite as to localization of the source.
5. Tender adnexa or uterus may be detected, especially tender uterosacral ligaments.
6. Replacement of a retrodisplaced uterus may give relief.

Crawford, Wickern, and Cave,[2] in discussing acute lower abdominal emergencies, referred to the conventional triad of pain, nausea and vomiting.

They reported the surgical emergencies at Roosevelt Hospital from 1940 to 1951 as due to:

1. Acute appendicitis
2. Acute diverticulitis
3. Intestinal obstruction
4. Traumatic injuries to the abdomen
5. Ruptured corpus hemorrhagicum
6. Acute ulcerative colitis
7. Ruptured ectopic pregnancy
8. Torsion of ovarian cyst
9. Acute salpingitis
10. Endometriosis

They further named as medical conditions that simulate a surgical condition of the abdomen as:

1. Diabetes mellitus
2. Uremia
3. Addison's disease
4. Acute congestive failure
5. Coronary thrombosis
6. Pericarditis
7. Dissecting aneurysm
8. Sickle cell anemia
9. Leukemia
10. Henock's purpura
11. Typhoid fever
12. Measles
13. Porphyria
14. Pneumonia
15. Serum sickness
16. Black widow spider bite
17. Tabes dorsalis
18. Herpes zoster
19. Intercostal neuralgia

Apparently no cases of drug addiction appeared in this group.

Characteristics of Chronic Pelvic Pain

The symptoms may be:

1. Aggravated by posture—usually when standing for long periods of time, but sometimes worse in the dorsal position.
2. Dyspareunia (more often confirmed after questioning than volunteered).
3. Associated with spastic or mucous colitis.
4. Dysuria is rarely the chief symptom, but is fairly frequently an elicited associated symptom.

Signs:

The signs of chronic pain may vary from identification of the etiologic factor to absence of signs. For this reason it is necessary to classify the type of pelvic pain according to the accredited etiology.

Pelvic pain is usually classified etiologically by the associated demonstrable pathologic condition and is considered as genital, extragenital, or in the absence of demonstrable pathologic change, psychogenic in origin. The physician should be cautious in explaining pelvic pain by existing pathologic evidence, but should be doubly wary of diagnosing neuroses in the absence of a detectable pelvic pathologic condition. The psychiatrist probably should not be the last to be consulted, but he certainly should not be the first.

The possibility of multiplicity of etiology must not be overlooked.

Findings in Patients with Pelvic Pain of Genital Origin

1. Tumors: (a) fibroids with pressure due to size or pain due to necrosis (fibroids alone rarely cause pain); (b) ovarian cyst — twisted.
2. Endometriosis (worse at time of period).
3. Adenomyosis (dysmenorrhea appears late in menstrual life).
4. Chronic salpingitis (tender abdomen with congestion and peritoneal irritation).
5. Uterine displacements.
6. Varicosities of genital organs.
7. Childbirth displacements.
8. Prolapse of ovary.
9. Parametritis.
10. Stimulation of cervix by (a) chemicals, (b) dilatation, (c) cervicitis and (d) ectropion.
11. General engorgement and tenderness with dysmenorrhea.
12. Dyspareunia (by history, vascular and congestive findings and change of mobility).

All are associated with pelvic congestion and probably vascular physiology.

Extragenital Origins

1. Pelvic varicosities.
2. Endocrine imbalance demonstrated by (a) inhibition of ovulation and (b) hypothyroidism.
3. Allergies (vascular physiology), "metrallergy" of Goodall and Power.[3]
4. Joint relaxations.
5. Diverticulitis.
6. Appendicitis.
7. Systemic: (a) tuberculosis and (b) Hodgkin's disease.
8. Anemias.

9. General debilitation (hypoproteinemia).
10. Rarely with blood dyscrasias.
11. Drug addiction.
12. Rarely with pelvic tumors (symptoms are pressure rather than pain).

These also all present the symptoms and findings of pelvic congestion and probably vascular physiology.

Psychogenic Origin

1. Acute shock
2. Chronic emotional imbalance

Duncan and Taylor[4] were convinced that the pelvic vascular system is highly responsive to states of mind because with a method dependent upon changes in thermal conductance, it was shown that variations in pelvic blood flow took place whenever, during a psychiatric interview, subjects were touched upon toward which the patient had special emotional attitudes. Yet who can show that pelvic congestion due to arteriospasm does not exist perhaps coincidentally?

Taylor[5] showed that pelvic pain usually occurs during the age periods of the twenties and thirties, that is, during the age of the greatest reproductive and sexual activity. Rarely is this clinical picture noted after the menopause. The occasional finding of tender postmenopausal uterosacral ligaments is hard to explain on a vascular congestive basis, but it has its place in this syndrome which, while called by several names, falls into the same pattern.

Schultz,[6] in 1875, and Freund,[7] in 1885, called it "chronic parametritis," implying an infectious or at least an inflammatory etiology.

Opitz[8] and Martius[9] explained uterosacral ligament tenderness as spastic smooth muscle.

Young[10] wrote of "broad ligament neuritis."

Cotte and Dechaume[11] came up with the term "congestion pelvienne" in 1931, although Gooch,[12] according to Taylor,[5] suggested the idea of "pelvic congestion" in 1831.

These and several other designations, including the "pelvic sympathetic syndrome" of Theobold,[13] are tags for the same syndrome. When one considers the hypersecretion of a swollen cyanotic eroded cervix with or without laceration, or when at celiotomy one sees the cyanotic soft nongravid uterus with an excess amount of amber-colored fluid in the cul-de-sac, it is natural to rationalize on the term "pelvic congestion." Well known is the example of the eroded posterior cervical lip in the patient with a retrodisplaced uterus that will recur after cauterization, but will often clear up without local treatment if the retrodisplacement of the uterus is corrected. It is also possible to theorize that prolonged congestion can result in fibrous tissue stimulation resulting in, for example, the bulky hypertrophied, hard or cyanotic cervix, or the so-called fibrocystic ovary. This congestive fibrosis syndrome, however, is still theory.

Cohen and his co-workers,[14] however, believed that pelvic discomfort may be manifestations entirely psychiatric in origin and hysterical in character, without somatic components, that the pain is imagined and restricted to the patient's mind. The experiment of Duncan and Taylor[4] dealing with the pelvic vascular system during psychiatric interviews would seem to refute this belief and point again to changes in pelvic vascular physiology.

The much discussed so-called primary dysmenorrhea, which is diagnosed in the absence of recognizable pathologic change in the pelvic organs, has not been satisfactorily proved to be entirely systemic, psychogenic, or hormonal in origin. Certain characteristics, however, of the pattern behavior of primary dysmenorrhea are known.

1. It usually begins shortly after menstruation is established.
2. It tends to be crampy in character and is associated with constitutional symptoms.
3. It seldom, if ever, occurs in the absence of ovulation.
4. It is often accompanied by underdevelopment of the genital organs.
5. It is diagnosed in the absence of recognizable pelvic pathologic change.
6. It usually disappears gradually after childbirth.
7. It is often associated with hypothyroidism.
8. It often occurs in emotionally unstable persons.

The psychogenic and hormonal origins have been most often advocated and hyperactive contractions of uterine muscle and arterial spasm most often offered as the explanation of dysmenorrhea. Smith and Smith[15] presented a theory of a menstrual toxin which is similar to the "Necrosin" described by Menkin.[16] Markee[17] showed that rapid regression of endometrium initiates the chain of events leading to menstrual bleeding, that this is dependent on the pituitary, ovarian, endometrial relationship, and that any interference with this relationship causes menstrual disturbance. Miller and Behrman[18] detected eco-

nomic as well as social and psychiatric aspects of dysmenorrhea. It would seem reasonable that these are aggravating rather than etiologic factors.

It is, however, more simply noted that with the onset of bleeding and the lessening of congestion, the pain of dysmenorrhea diminishes. Kimbrough[19] stated that he has "never seen crippling dysmenorrhea of the primary type in a girl who was well adjusted emotionally."

Taylor[5] presented as evidence that the local vascular condition is the dominant feature of pelvic pain:

1. The anatomic and mechanical factors resulting in change of pelvic intravenous pressure due to posture or faulty support.

2. Hormones, especially estrogens, cause hyperemia and increase tissue fluid in the hormone-controlled organs.

3. The presence of complicating inflammation can at least cause local hyperemia or congestion.

4. The sympathetic and parasympathetic nerves to the pelvis can cause vasodilatation and vasoconstriction.

The severity of symptoms parallels the vascular changes. They are most severe during the premenstrual period, when abnormal congestion is added to physiologic hyperemia, and subside with the shedding of the endometrium and bleeding which bring about relief of the congestion. As excessive vascularity of the pelvic organs is decreased with the menopause, the pelvic pain diminishes. Pain is often worse after coitus with its probable vascular hyperemia. Pelvic pain is usually aggravated by prolonged periods of standing and relieved by the recumbent position, but often by change of position and relief of venostasis.

Management of Pelvic Pain

1. Decide on the origin—whether genital, extragenital, or psychiatric.

2. Correction of the existing pathologic condition, whether by mechanical or medical means, or by restoration of normal endocrine balance.

3. Suppression of ovulation in true cases of primary dysmenorrhea.

4. Simplicity of therapy is advocated before resort to surgical, hormonal, or psychiatric therapy. The multiplicity of etiology must be considered and the several etiologic components recognized and appropriately treated.

5. Demonstrate a willingness to consult specialists in fields other than gynecology when indicated.

Summary

The possible and probable causes of pelvic pain are discussed.

The various synonyms for this syndrome are stated and theorized upon as all pertaining to the same syndrome.

Evidence is presented to substantiate the theory of "pelvic congestion" on a basis of vascular physiology.

A generalized statement is made as to the management of pelvic pain.

Conclusion

It would seem, therefore, that all pelvic pain evolves from some form of pelvic congestion, localized or general, and manifests its localization by the so-called visceromotor reflexes. These impulses are thought to be initiated by disturbances of pelvic vascular physiology. It is usually classified by the associated pathologic condition detected, and may be considered as genital, extragenital, or, in the absence of detectable pathologic change, as psychogenic in origin. One origin usually predominates, but the possibility of multiplicity of contributing factors cannot be discarded.

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Volume XLIII
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Peaceful Use of Atomic Energy Cobalt-60 Radiation Therapy at Mercy Hospital

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CORAL GABLES

Atomic medicine has come of age. Whether one likes it or not, nuclear fission products, useful in medicine, have survived an age of skepticism and are now in an era of real benefit to mankind. Their future rests with those who use them and thereby come to believe in them.

For the past few years, scientists in the atomic field have been looking for a suitable isotope capable of being used in the treatment of malignant disease. An isotope (short for radioisotope) is defined as an element which has been made radioactive by nuclear bombardment within an atomic reactor.

Such an isotope must ideally fulfil two necessary requirements. First, it must have a long enough half-life of radioactivity to be both economical and practical to use. Secondly, it must have a high energy quota so necessary for the destruction of cancer cells.

Cobalt 60 has been found to satisfy all the necessary requirements. As a result, today it is being widely used in the treatment of cancer. More and more each day, it is being used in therapy units in the hospitals of this country and in foreign hospitals. Today, it has become one of man's latest answers to the cancer problem.

The metal cobalt has to be "fried" in a nuclear reactor for a year to 18 months before it is ready to go to work in hospitals. The exposure in the reactor to low velocity neutrons causes the cobalt atoms to be "captured" by the thermal neutrons. The product formed is an isotope called cobalt 60. This isotope now is an unstable atom; having gained a neutron in its atomic structure, it emits radiation as a result. The radiation emitted has an energy of 1.2 million electron volts, which is equivalent to 3 million volt x-ray. This puts this type of radiation in the class of supervoltage. In addition, the emitted ray is monochromatic, that is, it emits rays of one quality, all with the same extremely short wave length. Hence, it is not necessary to use filters to filter out the longer wave length rays as in the conventional type of x-ray machine.

From the Department of Radiology, Mercy Hospital, Miami.

Cobalt 60 has a half-life of 5.3 years. This long half-life makes it extremely useful and practical as a source for the new therapy units. This means that it takes 5.3 years for it to lose half of its radioactivity. Actually, the source should be changed in three years so that the treatment time is not excessively prolonged and, thus, more patients can be treated daily.

Once the isotope in the reactor is ready for use, it is packed in an extremely small volume. About 200 pea-sized particles of cobalt 60 are crammed into a small cylinder. The amount of radiation emitted from this quantity is measured in curies. A curie, so called after Madame Curie, famous French physicist, is the amount of radiation which produces 37 million disintegrations per second. Most present day cobalt therapy units have 1,100 to 1,200 curies. Larger sources may be possible in the future.

The smaller cylinder containing the isotope is wrapped in two tons of lead before shipment to a hospital. Once the radioactive source arrives at its final destination, it is transferred to the therapy unit head in the hospital. Lead surrounds the container, thus shielding the powerful ray from the personnel engaged in the setting up of the patient for treatment. A series of lead shutters in the treatment head also protects the patient from the ray until the treatment is actually started. With the shutters opened, a collimated useful beam of radiation is then possible.

Treatment Technic

A radiation physicist can now measure the beam in air and in tissue—equivalent substances at a fixed and constant distance from the source. For example, at our hospital a dose of 37.5 r per minute in air at 75 cm. was obtained by the physicist actually measuring the radiation at that distance by delicate and sensitive equipment. Actual measurements of the radiation are made in tissue-like material at various levels, representing various depths in the body, and charts of these measurements are made. These are called isodose curves and are useful in calculating the amount

of radiation received by the tumor in the depth of the body.

The isodose curve of our cobalt 60 unit within any depth of the body is practically a straight line. This means that the margins of the treating field get almost as much of the radiation as the central portions, with a sharp drop-off at the edges of the field. Thus, a homogeneous area of radiation is possible. The sharp drop-off at the periphery prevents unnecessary radiation to surrounding structures. Radiation is thus possible only where it is needed, resulting in less radiation sickness.

As stated before, at our institution a dose of 37.5 r per minute at a distance of 75 cm. is possible from a 1,100 curie source for a 15 by 15 cm. field. As each month goes by, the r rate diminishes 1 per cent because of the decay factor of the radioactive source. It is only after three years of use that this decay becomes of serious import relative to the treating time of patients.

For the past few years, there has been persistent scientific interest in increasing the voltages in deep roentgen therapy. Present 1 and 2 mev generators, cobalt and betatron units, are the result of this effort.

The biologic effect on cancer cells is no different whether supervoltage or conventional x-ray is used. The effect is the same, namely, destructive. The real difference between the effects of the two types of radiation is a physical one. By reason of the high energies and the skin-sparing effects, a larger dose is permissible to a deep-seated cancer. In general, with supervoltage, the electrons in the radiation are propelled in a forward direction by the high energies. This phenomenon has been labeled the "Compton recoil" effect.

This Compton effect is responsible for the favorable skin reactions with supervoltage, allowing a larger dose to be administered to a deep-seated lesion. With cobalt 60 radiation, maximum ionization occurs at that distance below the skin surface where the Compton electrons have expounded their energy and stopped. This occurs 3 to 6 mm. below the skin surface. This range increases linearly with increase in the voltage.

In addition to the supervoltage advantage of our cobalt beam, rotational type of radiation is possible. This is a real step forward in the treatment of malignant disease and has come to the fore in the last few years. Many and varied setups and treatment plans are thus possible in the treatment of cancer.

The principle of rotational therapy depends on the rotation of the source of radiation around the patient. The treatment head follows the path of a sphere 360 degrees around the patient. All or segments of the 360 degree rotation may be used, according to the problem presented. If the lesion is centrally located in the body, complete rotation may be used. If the lesion is eccentrically placed in the body, only the more gainful segments of the 360 degrees arc are used. In the latter instance, the source pursues a backward and forward pendulum-like course around that portion of the body requiring the more intense and concentrated radiation; or a combination of a single straight port directed at the lesion from the nearest side, combined with an additional rotating port from the other side, may give a more homogeneous distribution of radiation to the lesion.

The back and forth pendulum type of radiation, so suitable to one-sided lesions in the body, is called scanning. In addition, an oscillating type of treatment plan is also possible. In the latter, the source will oscillate along the long axis of the body 22 degrees in either direction, cephalad or caudad. This form of movement could be of value in the treatment of apical lesions of the lungs, or lesions of the spinal cord.

It has been said by many wise physicians that the best method of treatment is the simplest. In other words the best method is that which involves the least degree of physical, psychic, or economic trauma. Certainly, the cobalt therapy unit at our institution satisfies all these dictates.

These principles are embodied in our equipment and in the actual treatment of each patient. Before treatment is begun, each new patient is coached on what to expect relative to the movements and noises made by the machine in operation. For those who still appear apprehensive even after the explanations, a "dry run" of the machine in operation is performed. This usually soothes even the most fearful or sick patient. It is believed that a contented and relaxed patient is far easier to treat than one worried and overwrought.

Once any uncertainty on the part of the patient is overcome, he is allowed to lie at ease on the treatment table. No straps, restraints, or fixation apparatus are ever used to hold the patient in position. This practice tends to ease any tension or concentration of the patient on maintaining his position on the treatment table. All, then, can proceed smoothly.

The tumor, which has been previously assessed as to size, location, and extent, is now lined

up to the source in two planes of the patient's body. Skin markings, which relate the tumor to points on the skin, are related to the localizing light, thus lining up the central ray of the x-ray beam to the tumor center. Once this is done, no further changes of either the patient or the equipment are necessary. A series of beam-directed treatments is now possible without the operator leaving the control panel. This procedure permits a higher work factor for the equipment and reduces the exposure to the operator.

The arrangement of the new therapy department at Mercy Hospital, with the last word in up-to-dateness of equipment, permits great facility in the care and handling of cancer patients, either as inpatients or outpatients. At the present time, a daily average of 30 patients is being treated with cobalt on an eight hour workday basis. Eighty-five per cent of the patients are being treated as outpatients. The average treating time is five to six minutes, depending on the dimensions of the patient.

After each patient completes his course of radiation therapy, he is encouraged to return to his referring physician for follow-up care. An adequate follow-up is also carried out simultaneously in this department. This serves as a double check of each patient.

Summary

The isotope cobalt 60 has been found to be suitable in every respect as the source of high voltage radiation in therapy units. It is equivalent to 3 million volt x-ray. Lesions deeply embedded in the depths of the body now can receive a cancerocidal dose without danger of untoward and limiting skin reactions. Such cancers of the lung, esophagus, pharynx, bladder and cervix can now receive more adequate dosages. Because of the physical characteristics of the radiation, it spares surrounding normal structures. It is kind to bone and cartilage, thus permitting treatment of tumors of bone, antral sinuses, and larynx. In truth, it may be said that it offers the most modern approach to the treatment of malignant disease known today.

1582 Zoreta Avenue (Dr. Ajac).
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Method of Teaching Diabetic Patients

GEORGE F. SCHMITT JR., M.D.
MIAMI

One of the most difficult and time-consuming tasks confronting a physician is the instruction of diabetic patients in the proper method of controlling their disease. During the past several years, I have developed a series of taped lectures, varying in length but of approximately an hour's duration, on general diabetic care, testing of urine, proper diet, and use of insulin. All diabetic pa-

From the Departments of Pharmacology and Medicine, School of Medicine, University of Miami.

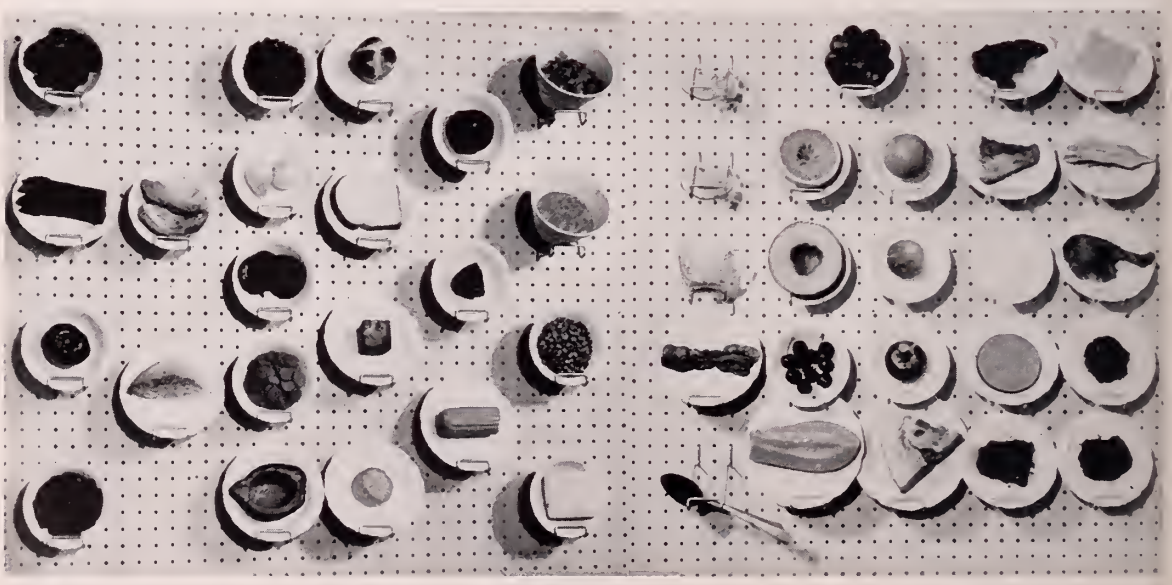

Figure 1.

tients are requested to attend these lectures on those mornings when there are no other appointments.

By the use of taped lectures, several patients at a time can be "personally instructed" in proper diabetic care. As a result, many hours each week that the average internist spends repeating lectures for individual patients are saved. Patients can attend the lectures as often as they wish. Many patients return in approximately six to nine months to listen again to the series.

Supplementing the lectures is a library of pamphlets on diabetes. The subjects covered by this educational literature include not only diabetes but also nutrition, cancer, peripheral vascular disease and other diseases to which the diabetic patient is liable.

Complementing the lectures and the literature is a three dimensional display of various foods (fig. 1), which has proved an effective means of educating patients in the proper nutritional needs.

This lecture and literature system is adaptable to other subjects, such as heart disease, and it is useful for dietary instruction in small hospitals without trained dietitians.

30 Southeast Eighth Street.

Natural Fluoridation in Jacksonville, Florida

Prevalence of Dental Caries, Tooth Mortality, and Fluorosis

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JACKSONVILLE

Water consumption of an individual depends to an extent on factors such as mean annual temperature, seasonal variation, humidity, and elevation above sea level. There is relationship between the water consumption of an individual and the amount of fluoride that should be present in drinking water.[1-7] The most effective fluoride concentration for a public water supply should be determined for each set of environmental conditions.[8]

The desirable fluoride concentration for any community's water supply is that amount which affords its population maximum protection against dental caries, with the minimal possibility of mottled enamel, which occurs in the teeth of persons living in communities whose water contains excessive amounts of naturally occurring fluoride.[9,10]

For the United States, fluoride concentration has been established at 1.0 to 1.5 parts per million, based primarily on epidemiologic studies of communities containing varying amounts of natural fluoride in their water supplies.[11] These study areas are in the Middle West, where the climate may be considered cool and dry, with mean annual temperatures of 50 F. or less, and with considerable seasonal variations. A special committee of the American Water Works Association estimated that 0.70 parts fluoride per million parts water may be sufficient and desirable for regions where the mean annual temperature is 70 F. or higher.[12] The need for epidemiologic studies in areas having more humid, warmer climates and naturally fluoridated water is apparent.[13]

Materials and Method

Jacksonville, Florida, is as representative as many other cities along the southern seaboard, and for many years its municipal water supply has contained a uniform amount of natural fluoride. Detailed records of its climatic environment and water supply are available. This city affords an excellent opportunity for studying the relationship between fluoride and dental health in warm coastal regions of the southeastern seaboard of this country.

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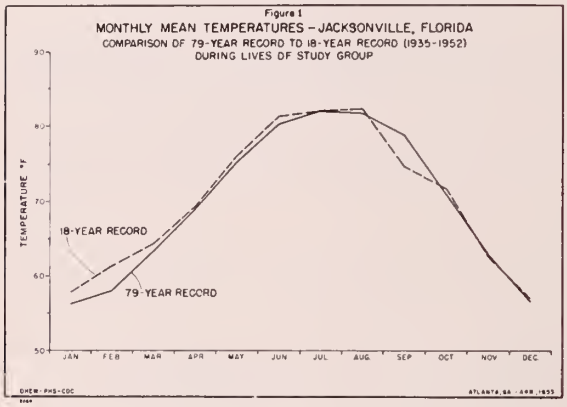
GEOGRAPHY. — Jacksonville (population 204,517)* is located in the northeastern portion of the Florida Peninsula. The city is situated along the St. Johns River estuary at an elevation equal to sea level some 18 miles from the Atlantic Ocean.

CLIMATE. — The annual mean temperature for the past 79 years has been 69.4 F., and for the past eight years it has been 70.4 F. For this same 79 year period there has been an annual mean seasonal variation of 25.5 degrees, seasonal temperatures ranging from a high of 82.0 F. in July to a low of 56.5 F. in January (fig. 1).[14]



A high annual rate of rainfall gives Jacksonville a definitely humid atmosphere. For the past 14 years, the average relative humidities have been: 87 per cent at 1:30 a.m. (EST), 87 per cent at 7:30 a.m., 55 per cent at 1:30 p.m. and 74 per cent at 7:30 p.m.[15]

Water Supply Data

SOURCE, TREATMENT, AND DISTRIBUTION. — For 72 years the Jacksonville Water Department has been the only public water supply for the city's population. Water has been supplied by free-flowing deep wells which are artesian in nature.

There are some 50 such wells, 45 of which are 1,000 feet or more in depth, that are scattered throughout the city's area. The deepest of these wells is 1,365 feet and the shallowest is 529 feet in depth.[16] All water obtained from these wells is pumped to a central reservoir, and thence into the citywide distribution system. The only treatment received by the water is aeration to remove hydrogen sulfide as water enters the reservoir, and chlorination as it leaves the reservoir.

FLUORIDE CONTENT. — Fluoride was first detected in Jacksonville's water in a series of analyses made July-September 1934. Seventeen samples were analyzed, including samples from individual wells and composites from the distribution system. Using the analytic methods of that era, fluoride concentrations were found in all samples which ranged from 0.55 parts per million to 0.75 parts per million. Distribution samples from the municipal supply were reported as having a fluoride content of 0.60 parts per million.*

Later analyses of distribution samples in 1946 disclosed concentrations of 0.60 parts per million, and using newer methods, of 0.70 parts per million in 1949 and 1951.† The same water-bearing aquifer, and also most of the same wells, have been in use since before fluoride was detected in 1934, and are used today.

These analyses, continuous use of same source wells, and similar fluoride contents of more recently drilled wells into the same aquifer are the basis for determining that the fluoride content of Jacksonville's water has been constant and uniform for more than 20 years.[17]

Dental Study Method

A dental study was made to determine: (1) The extent of protection against dental caries afforded by continuous use of Jacksonville's naturally fluoridated water[18] and (2) if this fluoride ion concentration is causing any harmful or esthetically objectionable dental fluorosis (mottled enamel).

STUDY GROUP. — Principals in all schools in the city distributed questionnaire cards to white children ranging in age from six through 17 years. Principals and classroom teachers in each school were impressed with the importance of distributing these cards to children of each socioeconomic level represented in their particular school. The objective of obtaining a thoroughly representative cross section of children in each age level was emphasized to these school officials.

After cursory screening, 21,000 children, nearly two thirds of all children in this age range, were given the questionnaire cards to be completed by their parents, containing these questions:

(1) Has your child lived within Jacksonville's city limits since birth?
(2) Has your child used the municipal water for drinking purposes since birth?
(3) Has your child *never* been absent from within the city limits for *more* than 30 days at one time?

*1950 Census.

*These analyses were performed by the University of Florida, Department of Chemistry, under the direction of Dr. A. P. Black, in cooperation with the Bureau of Sanitary Engineering of the Florida State Board of Health.
†Performed by Bureau of Laboratories, Florida State Board of Health.

Of the children thus sampled, there were 1,590 whose cards were returned by their parents answered "Yes." Of this number there were children in each age group from all of the schools, and school officials, county health department officials, and public health nurses confirmed that the study group was as representative of children of the city as possible who could meet the requirements for continuous exposure to the municipal water. The study group was composed of all white school children in the selected age range who had continuity of exposure to both the municipal water and the city's climate.

Dental Examination Procedure. — Each child was examined by a dentist in natural lighting using a No. 3 plain mirror and a No. 5 double end explorer. The clinical crowns of the permanent teeth* were carefully examined for any carious lesion.†

Dean's "Classification of Mottled Enamel Diagnosis" was the criterion used to determine macroscopically the presence of dental fluorosis, and to diagnose its severity.[19] Effort was made by the examiners to differentiate between fluorosis and other enamel dystrophies.[20]

The dental examinations of each child covered four specific categories in permanent dentition.

(1) Number of decayed, missing and filled (DMF) teeth.
(2) Number of extracted teeth as result of caries experience only.
(3) Number of teeth indicated for extraction as result of caries experience.
(4) Fluorosis classification.

Examination findings were recorded on appropriate forms (fig. 2).

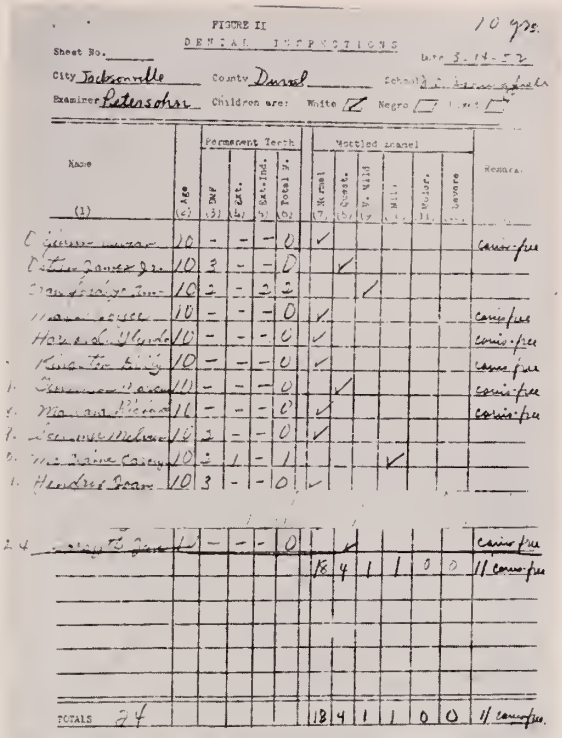


FIGURE II
DENTAL INSPECTIONS

Sheet No. ____ Date 3-14-57
City Jacksonville County Duval School
Examiner Petersohn Children are: White ☑ Negro ☐ Other ☐

Name (1)	Age (2)	Permanent Teeth: DMF (3)	Ext. (4)	Ext.-Ind. (5)	Total Ex. (6)	Mottled Enamel: Sl. mal (7)	Questn. (8)	V. Mild (9)	Mild (10)	Moder. (11)	Severe (12)	Remarks
[illegible]	10	-	-	-	0	✓						caries-free
[illegible]	10	3	-	-	0		✓					
[illegible]	10	2	-	2	2			✓				
[illegible]	10	-	-	-	0	✓						caries-free
[illegible]	10	-	-	-	0	✓						caries-free
[illegible]	10	-	-	-	0	✓						caries-free
[illegible]	10	-	-	-	0		✓					caries-free
[illegible]	10	-	-	-	0	✓						caries-free
[illegible]	10	2	-	-	0	✓						
[illegible]	10	2	1	-	1				✓			
[illegible]	10	3	-	-	0	✓						
[illegible]	10	-	-	-	0		✓					caries-free
TOTALS 24						18	4	1	1	0	0	11 caries-free

Annual Caries Incidence. — The caries attack rate, determined by method of least squares fitted to a straight line, is 0.345. This figure, 0.345, represents the average number of permanent teeth per child becoming carious per year among the Jacksonville children, between ages six and 17 years, who had had continuity of use of the naturally fluoridated water since birth.

Permanent Tooth Loss. — Of the study group, 1,393 children, 87.6 per cent, had no missing permanent teeth as the result of dental caries. The average rate of missing teeth per child varied

Table 1. — Caries Prevalence in Jacksonville, Florida, Children by Age Specific Groups Permanent Dentition

Age	Number of Children Examined	Percentage of Children Caries-Free	Average Number of DMF Teeth per Child*
6	96	92.7	.14
7	158	81.0	.61
8	171	53.2	1.01
9	140	44.3	1.34
10	123	43.9	1.43
11	123	40.3	1.60
12	109	47.7	1.81
13	150	31.7	2.75
14	193	34.2	2.52
15	115	23.5	3.28
16	116	24.1	3.47
17	96	19.7	4.26
Totals	1,590		

*DMF (Decayed, Missing, and Filled) is a cumulative index of the entire caries experience of an individual representing the total of the number of permanent teeth that are: (1) Carious (D), (2) Missing as result of caries (M), and (3) Filled because of caries (F).

Findings

Caries Prevalence in Permanent Teeth (Table 1). — Of the 1,590 children, 710 children, or 44.6 per cent, had experienced no caries in permanent teeth. The distribution of these "caries-free" children by age groups is shown in table 1.‡ The DMF rates increased with age from 0.14 teeth at age six to 4.26 teeth at age 17.

*Third molars excluded.

†All dental examinations in this study were performed by the same two examiners. Prior to the actual study, a special test group of 50 children was examined separately by each dentist. Findings were recorded separately, and later compared. When findings differed, the child was re-examined. Differences of interpretation of clinical evidence of caries were detected and reconciled. Diagnostic accord was thus reached between the two examiners.

‡Classification of "caries-free" means that the child had no active carious lesions, none that had been corrected by fillings, and no teeth missing as the result of caries, or, no DMF teeth.

Table 2. — Permanent Tooth Mortality in Jacksonville, Florida, Children by Age Specific Groups Permanent Dentition

Age	Percentage With No Permanent Tooth Loss	Average Number of Missing Permanent Teeth* Per Child
6	100.0	0
7	100.0	0
8	97.0	.04
9	94.2	.03
10	93.5	.09
11	87.6	.16
12	79.8	.23
13	68.5	.20
14	87.0	.21
15	70.4	.30
16	82.7	.32
17	86.4	.32

*Includes teeth indicated for extraction.

from none at age six to 0.32 at age 17. Tooth mortality in the study group is shown in table 2.

FLUOROSIS EXPERIENCE. — There were four cases of "mild" dental fluorosis and 119 cases of "very mild" fluorosis. The 123 children with definite macroscopic evidence of fluorosis represent 7.5 per cent of the study group. Of the remaining 92.5 per cent, 182 children were classified as "questionable," and 1,285 children were "normal."

Dean[19] described "mild" fluorosis as: "The white opaque areas in the enamel of the teeth involve at least one-half of the tooth surface. The surface of molars, bicuspids, and cuspids subject to attrition show their white layers worn off and bluish shades of underlying enamel normal. Light brown stains are sometimes apparent on the superior incisors."

No case of greater severity than "mild" was observed. There were no cases in which brown stains or discoloration of enamel were found. There were no cases of fluorosis in which physical enamel defects or esthetically objectionable appearance of the teeth was observed.

Fine white striations, involving incisal edges, tips of cusps, and occlusal portions of tooth crowns were observed in "very mild" cases. White opaque areas were observed, which involved at least half the tooth surfaces of second molars, bicuspids, and cuspids, particularly in the "mild" cases.

EVALUATION OF FINDINGS. — Data of caries and fluorosis prevalence gathered in this study were compared to similar data from Aurora, Illinois. Aurora was one of the cities in which epidemiologic studies disclosed a sufficient amount of naturally occurring fluoride in its water supply to reduce effectively the incidence of dental caries without causing severe fluorosis.[11] Dental examinations, screening of the study group for continuity of residence and exposure to the public water, technic of dental examinations, tabulation, and statistical analysis of findings were conducted in the same manner in both of these studies.

Data from the Aurora studies were used as a standard to which results of pilot studies on fluoridation in Grand Rapids, Michigan, were compared and evaluated.[21] It was on the basis of studies in Aurora and neighboring cities with similar water-borne fluorides that the determination was first made that 1.0 parts per million concentrations would effect a caries reduction of 60 to 65 per cent.[22]

GEOGRAPHY AND CLIMATE. — Located in Northern Illinois, Aurora (population 50,576) is situated some 50 miles west of Chicago at an elevation of 678 feet above sea level. The annual mean temperature is 48.2 F. with a seasonal variation of 51.8 degrees.[23] Humidity readings are not recorded in Aurora, but are available for the metropolitan Chicago area. Average summer humidities are 55 per cent.* The Chicago Weather Bureau office stated that the humidity of this area is low enough to make the atmosphere rather dry, and heated air must be moistened for comfort.[24]

FLUORIDE CONTENT. — Aurora's water, obtained from deep wells, has a natural fluoride content determined to be uniform at 1.2 parts per million. This water was consumed by children in the dental study group with continuity of exposure from birth.

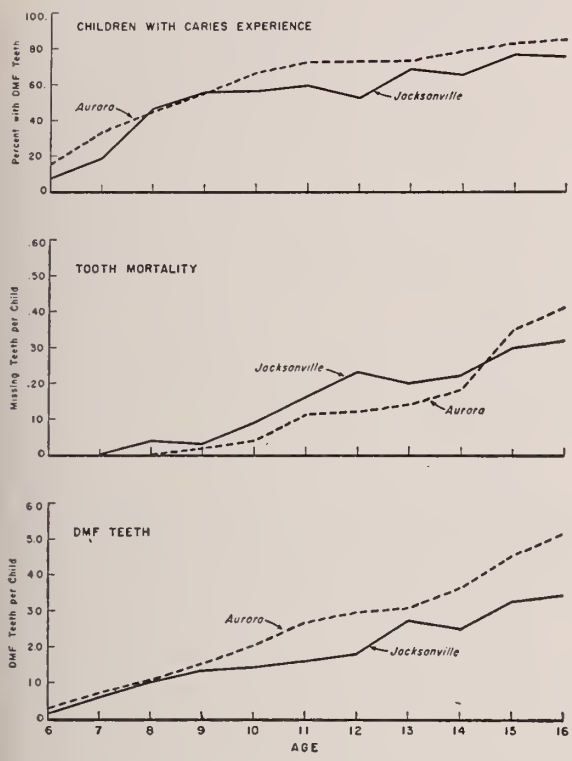
CARIES PREVALENCE (Figure 3). — Caries prevalence, based on DMF rates, tooth mortality, and percentage of "caries-free" children, is lower in Jacksonville than in Aurora. By age 16, the average child in Jacksonville's study group had 1.68 fewer DMF teeth than a child of the same age in the Aurora study group. Permanent tooth mortality is essentially the same in both cities up to age 12, at which point Aurora's rises above Jacksonville's.

The percentage of children with no caries experience is higher in Jacksonville for the over-all study group and is higher in most specific age groups than in Aurora's.

FLUOROSIS EXPERIENCE. — Less fluorosis of the "very mild" and "mild" types was observed in the Jacksonville study group. No cases of greater severity than "mild" were observed in

*Only summer humidities were recorded by the Chicago Weather Bureau during the time interval included in the lives of children in the Aurora study group.

FIGURE III
COMPARISON CARIES PREVALENCE
AURORA, ILL. (1.2 ppm F) AND JACKSONVILLE, FLA. (.7 ppm F)



either city. The incidence of fluorosis in Jacksonville is 13.0 per cent compared to 15.0 per cent in Aurora.[25] Fluorosis experience for the study groups of both cities is shown in table 3.

Summary

Dental findings of a study group of 1,590 white children, ages six through 17 years, having continuity of exposure since birth to Jacksonville's naturally fluoridated water (0.60-0.70 parts per million fluoride), and comparison of these findings with data obtained in a similar manner from Aurora, Illinois (1.2 parts per million fluoride) suggest these conclusions:

1. The naturally occurring fluoride content, 0.60 to 0.70 parts per million, of Jacksonville's communal water supply is providing a protection against dental caries for persons with continuous use of this water during the calcification of their permanent dentitions.

2. The degree of caries reduction effected appears to be as adequate as any yet found in other communities whose public water supplies contain higher concentrations of fluorine.

3. Since no objectionable or harmful fluorosis has resulted, no need to *decrease* the natural fluoride content of Jacksonville's communal water is indicated.

4. On the basis of present knowledge of the effectivenesses of water fluoridation, there is no reason to believe that any increase in the present

Table 3. — Comparison of Fluorosis Experience,* Aurora, Illinois† and Jacksonville, Florida: Incidence and Distribution According to Degree of Affection

Macroscopic Signs of Fluorosis		Aurora, Ill. 1.2 ppm F.	Jacksonville, Fla. 0.7 ppm F.
		(A) Number	
Total number of children examined		633	453‡
Fluorosis Absent	Normal	337	350
	Questionable	201	44
Fluorosis Present	Very mild	88	56
	Mild	7	3
	Moderate	0	0
		(B) Per Cent	
Total examined		100.00	100.00
Fluorosis Absent	Normal	53.2	77.3
	Questionable	31.8	9.7
Fluorosis Present	Very mild	13.9	12.4
	Mild	1.1	0.6
	Moderate	0	0
Incidence of affection		15.0	13.0

*Dean's "Classification of Mottled Enamel Diagnosis," pages 398-400 of Gordon's "Dental Science and Dental Art."
†Aurora data contained in Dean, H. T.; Jay, P.; Arnold, F. A. Jr., and Elvove, E.: Domestic Water and Dental Caries II, Pub. Health Rep. 56:15, April 11, 1941, table 9.
‡Fluorosis in Jacksonville as it occurred in the age groups 12-14 years compared here because those were the ages examined in the Aurora study group.

fluoride content of Jacksonville's communal water would effect any greater protection against dental caries.

Acknowledgments: The authors are grateful to the various persons and official agencies whose participation and assistance made this study possible. Valuable cooperation and assistance were rendered the Bureau of Dental Health, Florida State Board of Health and the Public Health Service by the following: Parents of the children who constituted the study group; Duval County Board of Public Instruction, the principals, and the teachers in the schools in which the dental examinations were performed; Bureaus of Sanitary Engineering and Laboratories of the Florida State Board of Health; Mr. Charles Helwick, Superintendent, Jacksonville Water Department; Dr. A. A. Rielly, Member, Jacksonville Dental Society; U. S. Weather Bureau Offices, Jacksonville, Florida, and Chicago, Illinois; John V. Miner, Senior Assistant Sanitary Engineer, U. S. Public Health Service Water Supply Consultant, Region IV; Miss Mary Quaw, Dental Health Educator, Bureau of Dental Health, Florida State Board of Health; A. W. Petersohn, D.D.S., Public Health Dentist, Bureau of Dental Health, Florida State Board of Health.

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ABSTRACTS

Use of Solid Foods Early in Infancy. By Walter W. Sackett, Jr., M.D. GP 14:98-102 (Sept.) 1956.

This report concerns the introduction of solid foods within the first few days of infant life, along with the initial use of a six hour feeding interval. This in turn is rapidly converted to a three-meal-a-day schedule. This program has been used during a five year period for approximately 600 babies. From this experience it is apparent that both the infants and their parents get along well when solid foods are introduced in the infant's diet soon after birth. Dr. Sackett discusses the basic principles and methods, observations and results, results observed by other physicians, and advantages and alleged disadvantages. He presents the six hour feeding schedule and results of the questionnaire sent to mothers.

A New Diagnostic Procedure for Cancer of the Rectum Using the Rectal Brush. By J. Ernest Ayre, M.D. Am. J. Surg. 90:668-670 (Oct.) 1955.

This author, who described a crude technic in 1950 for preliminary diagnosis of rectal cancer by cytology, here presents a new and superior method of collecting cells directly from the lesion as an effective diagnostic aid to surgical biopsy. This method employs a retractable rectal brush which may be readily used with a sigmoidoscope. It is suggested that in early malignancy or in precancerous rectal polyps the sweeping together of cells from the surfaces of one or more rectal polyps may increase the accuracy of diagnosis by providing the cytologist with representative cells from diseased tissue areas. As a preliminary diagnostic method preceding surgical biopsy, brush cytology presents a quick, practical aid for use in

the physician's office when the patient is first seen.

It is pointed out that the prompt establishment of preliminary diagnosis is of great importance to the patient in overcoming the delay interval so commonly encountered before final diagnosis of a suspect lesion is established. Preliminary cell diagnosis of malignancy also is of importance to the surgeon preceding biopsy or surgical therapy, frequently making it possible both to avoid delay and to obviate the need for multiple stage surgical therapy.

External Otitis: A Method of Therapy and Prophylaxis. By Henry E. Branca, M.D., F.A.C.S. A. M. A. Arch. Otolaryng. 63:459-465 (May) 1956.

Recent investigations into the etiology and pathogenesis of external otitis have brought about a more rational method of therapy and possibly prophylaxis. This article presents a review of the recent literature on the subject, demonstrates the seasonal incidence of external otitis for four years in South Florida, shows diagrammatically the "cycle of external otitis" and gives the therapeutic measures needed during each stage. The successful use of chloramphenicol (Chloromycetin) and polymyxin in the "bacterial stage" of the disease and the effective use of boric acid ointment in prophylaxis are reported. Cortisporin, a preparation containing polymyxin B sulfate preparation, neomycin and hydrocortisone, is reported to be surprisingly beneficial in "old" cases of external otitis. The treatment advocated for infectious eczematoid dermatitis involving the ears and, at times, the eyelids is staphylococcic-toxoid and antibiotic-corticosteriod combinations. Fourteen cases are presented demonstrating the varying characteristics of external otitis and the modes of therapy.

Myxoma of the Left Atrium. By Elwyn Evans, M.D. South. M. J. 49:979-981 (Sept.) 1956.

The surgical removal of benign tumors from a heart chamber has been unsuccessful so far. Now, however, preoperative diagnosis is possible by angiocardiography, and progress in operative technics will permit success at some time in the near future. The consensus is that tumors of the heart are rare, that most of the primary tumors of the heart are benign, and that most of the benign tumors are myxomas which appear as pedunculated tumors in the left atrium. The main reasons for not considering myxomas in antemortem diagnoses have been the lack of knowledge about them and, more important, the common fault of not thinking of them.

A case of functional mitral stenosis caused by a myxoma in the left atrium is presented. The symptoms were not altered with changes in body position, probably because the tumor had a broad base and maintained a constant position in relation to the mitral orifice. The findings which should lead to an early antemortem diagnosis are discussed. The most important of these are signs and symptoms of mitral stenosis which alter with changes in body position, and intractable heart failure. The importance of early diagnosis is emphasized because the only possible curative treatment is surgical removal of the tumor, and this is most likely to be accomplished early.

Rapid Subsidence of Hydronephrosis: Obstruction of Bladder Neck Due to Carcinoma of the Cervix. By Benedict R. Harrow, M. D. Am. J. Surg. 91:833-838 (May) 1956.

The amazing capacity for functional and structural recovery of the kidneys after relief of obstruction has been reported many times, but the rapid rate at which the obstructive hydronephrosis can decrease with return to a normal state has not been fully appreciated. Two cases are here presented in which pronounced hydronephrosis due to urinary retention receded in five to six days of drainage by catheter with return to a normal condition. In the first case there was great decrease in the hydronephrosis within 15 minutes after release of the urinary retention. Such immediate quick changes are attributed to muscular contracture. The second case illustrates a rare type of obstruction of the neck of the bladder due to a median bar from metastatic cervical carcinoma. The difficulty of differentiating between late radiation effects and recurrent cervical carcinoma is discussed, as well as the relationships to treatment.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

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Handling Insurance Problems

The changing events in the social and economic structure of this country during the last 25 years have not been without effect on the practice of medicine.

Formerly, it was the exception rather than the rule if the doctor's patient required the execution of various forms requested by insurance companies, welfare agencies, or other groups in establishing benefits claimed by the sick or injured. Today, probably 75 per cent of all patients have forms of one kind or another for the doctors' offices to complete. Most medical men shudder at this situation known as "paper work." It should be accepted, however, and adequate stenographic service provided.

Prior to the establishment of the Blue Shield, which was formulated to provide service for the low income group, the interest of the insurance companies in health and accident insurance was minimal. The stimulus of the Blue Shield, however, has caused commercial insurance companies to become actively engaged in this type of business.

Many of them write excellent policies. On the other hand, there are some that sell policies using chicanery and misrepresentations, leading the insured to believe in case of sickness or accident his medical expenses will be fully paid. When the time arrives to claim these benefits, the patient finds that he is indemnified for only a small portion of his financial obligation. In his disappointment, it is not uncommon for him to hold the doctor responsible for this deficiency. In light of the present circumstances, it is the duty of the doctors' offices to explain to the patient the deficiency of the policy of that type.

Not infrequently, the doctor is called to attend the injured in automobile collisions or other accidents of a similar character. In practically all these cases some form of public liability insurance is involved. In the majority of cases, the patient expects the doctor to look to the insurance company for his fee. Quite often the cases are in dispute and end in litigation. Often financial recovery is far less than expected and, as a result, the doctor is requested to reduce his charges. It should be remembered that in public liability cases there is no financial responsibility between the insurance company and the doctor, the obligation being entirely between the company and the patient. As a matter of courtesy, however, the insurance company will

often incorporate the doctor's name on the draft made in settlement.

In order to avoid the difficulties mentioned, it is wise to discuss these matters with the patient in the beginning.

Occasionally, the attorney representing the patient will request a reduction in the medical bill because of what he considers an inadequate settlement. In cases of this character, it is believed the doctor has a perfect right to have access to all details of the financial settlement and in no case should be expected to accept a reduction in his charges that the attorney does not share in the same ratio.

In the past, the doctor used to be the patient's councilor, not only in matters of illness or family affairs, but also business and financial as well. This was the finest kind of public relations. A return to being the personal business advisor will serve this worthy relationship better than newspaper, radio or any other public media. Time spent in the execution of this duty will be well expended in annealing the relationship between the doctor and his patient as well as the profession as a whole.

Scientific Program of Annual Meeting Hollywood, May 5-8, 1957

With the Eighty-Third Annual Meeting of the Florida Medical Association only two months away, plans are rapidly maturing for an outstanding convention. The Hollywood Beach Hotel, a frequent meeting place in the past, will welcome the Association members again this year and place its excellent facilities at their disposal from May 5 through May 8.

The program is arranged to expedite the work of the various groups and to permit the members to enjoy the many recreational attractions of the area. An innovation is the scheduling of two scientific assemblies only, both on Tuesday. This arrangement gives members who can come for but one day the opportunity to be present for the chief scientific activities and to participate in the major social events, which are planned for Tuesday night.

The First Scientific Session will begin at 9:30 a.m. on Tuesday and continue until 12:30. Three medical papers will comprise the first half of the program, and there will follow a panel on Cardiovascular Surgery. Opening at 2 p.m., the Second Scientific Session will continue until 5 p.m., and the program will consist of three surgical papers and a panel on Cancer.

Dr. Sherman B. Forbes of Tampa will present the first scientific paper at the morning session. His subject will be "Ocular Toxoplasmosis."

The second essayist will be Dr. Hyman J. Roberts of West Palm Beach. "Hazards in the Management of Peptic Ulcer with Anticholinergic Drugs: A Re-emphasis" is the title of the paper he will present.

The last of the three medical papers on the program will be presented by Dr. Augustus E. Anderson Jr. of Arlington. He has chosen for his subject "Diffuse Idiopathic Pulmonary Fibrosis."

Two of the participants in the Panel on Cardiovascular Surgery will be Dr. Robert S. Litwak of Miami and Dr. Philip Samet of Miami Beach. Dr. Litwak will speak on "Surgical and Physiologic Considerations in the Development of an Artificial Heart-Lung for Clinical Use." Dr. Samet's subject will be "Value of Combined Heart Catheterization in the Selection of Patients for Valvular Heart Surgery."

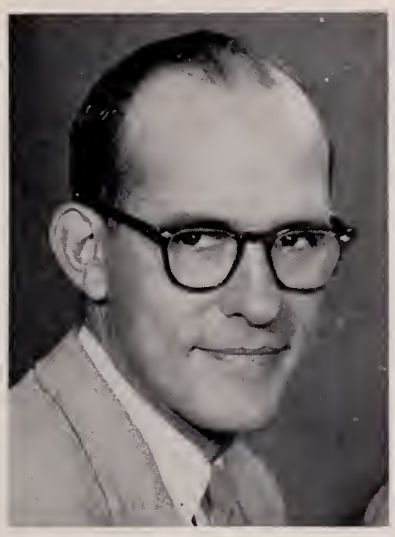
Presenting one of the papers on surgical subjects at the Second Scientific Session on Tuesday afternoon will be Dr. James D. Moody of Orlando. His subject will be "Reconstructive Arterial Surgery."

Dr. Bernard L. N. Morgan of Jacksonville will present another surgical paper. He will discuss "Facial Fractures, Their Recognition and Management."

Dr. Wesley W. Wilson of Tampa and Dr. Howard C. Duckett Jr. and Dr. Sam W. Denham of Jacksonville will participate in the Panel on Cancer, which will conclude the scientific activities of the convention. "Incidence of Skin Cancer Arising from Precancerous Dermatoses" is the title of the paper Dr. Wilson will present. Dr. Duckett's subject is "Sarcoma Botryoides," and Dr. Denham will discuss "New Technics in the Study of Carcinoma of the Uterine Cervix."

The program for the Annual Meeting will be published in its entirety in the April issue of The Journal. The stimulating program, the distinguished guest speakers, and the opportunity for fellowship and diversion should spur the members of the Association to attend in large numbers.

Florida physicians appearing on the program of the First Scientific Assembly are shown in order of their appearance: (upper left) Dr. Sherman B. Forbes, Tampa; (center) Dr. Hyman J. Roberts, West Palm Beach; (lower left) Dr. Augustus E. Anderson, Jacksonville; (upper right) Dr. Robert S. Litwak, Miami, and (lower right) Dr. Philip Samet, Miami.



Physicians from Florida appearing on the program of the Second Scientific Assembly are shown in order of their appearance: (upper left) Dr. James D. Moody, Orlando; (lower left) Dr. Bernard L. N. Morgan, Jacksonville; (upper right) Dr. Wesley W. Wilson, Tampa; (center) Dr. Howard C. Duckett Jr., Jacksonville, and (lower right) Dr. Sam W. Denham, Jacksonville.

Florida Medical Association Poliomyelitis Vaccination Drive March 1 to June 30, 1957

This month the Florida Medical Association is launching an all out drive to promote the use of poliomyelitis vaccine which will continue through the month of June. Through its component county medical societies the Association is promoting this program to provide leadership by its members in a statewide effort to vaccinate every person under the age of 40 years and to include those over 40 years of age when deemed advisable. Cooperating in this important project are the Florida State Board of Health and the respective county health departments.

Apathy of the public toward protection from poliomyelitis by vaccination has become a matter of nationwide concern. It is both timely and peculiarly fitting, therefore, that the Association, under the direction of its Poliomyelitis Medical Advisory Committee, of which Dr. Richard G. Skinner Jr., of Jacksonville, is chairman, should engage in this worthy endeavor.

Florida has about 3,876,000 citizens, and it is estimated that approximately 2,000,000 are under 40 years of age. The 364 cases of poliomyelitis reported during 1956 to the State Board of Health represented an impressive decrease of 47 per cent from the number reported before the Salk vaccine was available. The average yearly number for the 1951-1955 period was 781. In Florida, as elsewhere in the United States, there appears to be an increasing incidence of the disease among adults. One third of the cases of paralytic poliomyelitis have been among those over 20 years of age.

Records to December 31 of last year show that 127,781 persons in the state had received one injection of the vaccine, 414,553 two injections, and 148,284 the three injections recommended. These figures indicate the magnitude of the task the Association is undertaking. Those in need of this safe, effective vaccine for themselves or for those for whom they are responsible carry a heavy responsibility for the elimination of paralytic polio. Sharing this responsibility, however, are those in a position to provide leadership in disseminating information, shaping public opinion and administering the vaccine. The members of the Association are engaging in this drive to meet their responsibility in the matter and provide the needed leadership. Every member has an important role in this capacity.

The drive began on March 1, and a high measure of success is anticipated by June 30, the closing date. The program maintains the doctor-patient relationship by providing that vaccinations be obtained from the individual's personal physician. Mass inoculations are being discouraged, but determination of inoculation policies is left to the discretion of the respective county medical societies.

The Association seeks on a state level to (1) promote participation by each component county medical society, (2) provide details of the program to each component county medical society, (3) enlist support of each member through letters, newsletters and other media as deemed advisable, (4) provide coordination between statewide groups and agencies which participate in the program, (5) initiate all statewide publicity and promotion of the program, and (6) provide speakers to appear before county medical societies when requested.

At the county level, the component county medical society assumes responsibility for leadership and coordination of the program. It is expected to (1) designate a committee to be responsible for the program in the area, (2) establish inoculation policies and procedures, (3) enlist the support of all community groups deemed suitable to conduct educational efforts, (4) accept all publicity and promotion responsibilities associated with carrying out the program in the area, (5) encourage each member to assist in administering the vaccine and to charge a nominal fee to avoid any barrier to vaccination on the ground of availability and cost, and (6) provide for vaccination of indigent persons.

Dr. Skinner and his committee are making every effort to implement this comprehensive program at the state and county levels. Through the officers of each county society they are urging the fullest cooperation of all the component societies and the enthusiastic participation of each and every individual member. The measure of the program's success rests with every member of the Association and his willingness to participate locally.

Aid For Hungarian Refugee Physicians Urged

The World Medical Association announced recently its efforts to aid Hungarian refugees having professional or technical skills in the medical field to enable them to enter useful lives in the United States. A special appeal has been made to leading physicians and American pharmaceutical and medically related firms which are Corporate Members of the United States Committee of The World Medical Association, to aid in restoring the numerous Hungarian physicians to a useful place in the community.

Dr. Louis H. Bauer, Secretary General of The World Medical Association, said that many Hungarian physicians have been compelled to attempt escape to Austria because the A.V.O. (Hungarian Secret Police) has been arresting all doctors in Hungary who treated injured revolutionaries and failed to report their services as required by law.

The World Medical Association effort, Dr. Bauer explained, takes two forms: one, an appeal to physician members of its United States Committee for employment opportunities for medically qualified refugees; and second, an appeal to corporate members of the United States Committee for advice on employment opportunities, and positions that might be made available to these medical refugees.

Of the first 3,000 refugees arriving in the United States, Dr. Bauer said, 20 were physicians, and 17 were qualified technicians in various fields of medical service. Sponsoring agencies at the receiving centers have been asked to provide The World Medical Association Secretariat in New York with specific information on the needs and qualifications of all refugees who have medical backgrounds or skills.

With more and more Hungarian physicians entering this country, The World Medical Association and the Health Resources Advisory Committee of the Office of Defense Mobilization in Washington have asked the American Medical Association and its constituent societies to do everything possible to help these men and women who have fled from their homeland. The Health Resources Advisory Committee adopted a resolution, urging "every American health organization and educational institution to make every effort to lend its aid and resources toward the re-establishment of our new professionl colleagues in situations commensurate with their professional status. . . . To the dignity of political and personal freedom, let us help give them the dignity of professional status."

Medical societies are urged to ascertain immediately whether any Hungarian physicians have come into their communities and, if so, plan some program for them so that their professional talents will be utilized in the most effective way possible.

Medicine's Contribution to World Peace

Medicine is universally recognized as one of the great worldwide arts and sciences that bind humanity together with a language and a purpose transcending all differences of race, creed or color.

To make the language of medicine more articulate in the cause of international peace and human progress, the doctors of the free world are united in The World Medical Association, whose membership now embraces 53 national medical associations.

It is never enough, however, to establish great institutions. Only when individuals are given an opportunity to play an active part does any human organization "come alive" and begin to realize its basic purposes.

Every American doctor knows first hand the vital role he may play in guiding and protecting his profession by becoming an active member of his county, state and national medical societies.

Today, every American doctor has the opportunity—and the imperative challenge—to help make our profession a stronger influence for world peace. This he may do by joining our own United States Committee of The World Medical Association.

Similar "supporting committees" have been organized in a number of other leading nations whose national medical societies, like the A.M.A., are members of W.M.A.

In a timely action, W.M.A., at its 10th General Assembly in Havana in October, adopted a six point program to implement one of its constitutional purposes: to promote world peace. This program includes the development of mutual exchange visits of foreign doctors; exchanges of distinguished medical teachers; establishment by each W.M.A. member national association of an "international visitor's bureau;" stimulation of visits by representatives of member associations to the annual meetings of other member associations; holiday exchange programs between doctors and their families; and exchanges of text books and medical and scientific publications.

To implement this program takes money—and interested members. YOU may play your part by joining the U. S. Committee of W.M.A. Active membership dues for 1957 are $10.00. To join the U. S. Committee—and to learn how you can contribute to this great cause—communicate with Francis T. Holland, M.D., Chairman, State Committee of The World Medical Association, 1307 Miccosukee Road, Tallahassee, or contact the committee member in your area.

Dr. Holland has just announced the members of his committee as Dr. Henry L. Harrell, of Ocala, Dr. Samuel M. Day, of Jacksonville, Dr. Edward R. Annis, of Miami, and Dr. Don C. Robertson, of Orlando.

Graduate Medical Education

Short Course
June 24-28, 1957

June 24-28 will be the dates for the Twenty-Fifth Annual Graduate Short Course presented by the Division of Postgraduate Education of the College of Medicine of the University of Florida in cooperation with the Florida Medical Association and the Florida State Board of Health. This year the Short Course will be held at the Medical Science Building of the College of Medicine in Gainesville, thereby enabling the physicians of the state to have an opportunity to meet the staff of the medical school and observe the facilities and activities at the end of its first year of operation in addition to attending the regularly scheduled lectures. The program will include lectures on Medicine by Dr. James V. Warren, Professor of Medicine, Duke University School of Medicine; on Gynecology by Dr. Howard W. Jones Jr., Assistant Professor of Gynecology, The Johns Hopkins University School of Medicine; on Pediatrics and on Surgery. More details of the program will be published in the next issue of The Journal.

Seminar on Hematology

A Seminar on Hematology will be presented just prior to the Short Course, also at the College of Medicine in Gainesville. This program will be presented by an outstanding authority in this field assisted by the staff of the College of Medicine. Demonstrations on various phases of the subject will be included in the program.

The program of the Eighty-Third Annual Convention of the Association will be published in the April issue of The Journal.

Florida Society of Ophthalmology and Otolaryngology Midwinter Meeting Held

For the ninth consecutive year, the Florida Society of Ophthalmology and Otolaryngology held its midwinter convention in Miami Beach in January. As is customary, it met at midweek during the annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology.

At the scientific session on Wednesday afternoon, January 16, the guest speaker was Major General Dan C. Ogle, Surgeon General of the Air Force. President Blackburn W. Lowry presided. A representative number of members from throughout the state and the large number of guest-physicians who were attending the Seminar made the attendance record unusually high. Following the scientific assembly, which was held in the Seville Hotel, the members and guests and their wives spent an enjoyable social hour together in the hotel. Later, the members and many guests attended the annual dinner.

Record Attendance At Midwinter Seminar

The Eleventh Annual University of Florida Midwinter Seminar in Ophthalmology and Otolaryngology was held at the Seville Hotel in Miami Beach the week of January 14. Enthusiasm for this meeting, which has grown steadily through the years, reached a new peak this year. The 1957 registration was 370. Thirty-nine states were represented, and there were five registrants from Canada.

The Seminar is a major event in Florida's program of postgraduate medical education which has won nationwide acclaim. An innovation this year was the arrangement of the schedule so that each day practically the entire afternoon was available for recreation. As in the past, the program for the first three days of the week was devoted to Ophthalmology and for the last three days to Otolaryngology.

The lecturers on Ophthalmology were Dr. Francis H. Adler of Philadelphia, Dr. Harold W. Brown of New York City, Dr. Cecil W. Lepard of Detroit. Dr. Irving H. Leopold of Philadelphia and Dr. Algernon B. Reese of New York City. Lecturing on Otolaryngology were Dr. James B. Costen of St. Louis, Dr. Lester Hale of Gainesville, Dr. Philip E. Meltzer of Boston, Dr. Alden

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All physicians attending the Seminar were invited to attend the 1957 Midwinter Convention of the Florida Society of Ophthalmology and Otolaryngology, held at the same hotel on Wednesday afternoon, January 16. This meeting was followed by the usual midweek social features. Registrants and their wives were guests at an informal gathering at the cocktail hour. That night the annual dinner was held with more than 400 in attendance.

Association's Fair Exhibits Receive Public Acclaim

Highly successful fair exhibit projects were carried out by the Florida Medical Association and several of its component county medical societies during the 1956-57 fall and winter fair seasons.

"Accidental Poisoning in Children" was the theme of an exhibit sponsored by the Escambia County Medical Society in the Pensacola Interstate Fair held October 15-21, 1956. The exhibit coincided with the opening of poison control centers in local hospitals. More than 9,000 informational pamphlets were handed out to fair visitors by members of the Escambia County Medical Society and its Woman's Auxiliary. Much of the exhibit's success was attributed to excellent pre-fair preparations highlighted by a joint planning conference. The meeting was attended by the president and public relations committee chairman of the society, the president and vice president of the Woman's Auxiliary to the society and a representative from the Bureau of Public Relations of the Florida Medical Association.

The popular exhibit "Life Begins" was displayed by physicians of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, October 23-27, in the North Florida Fair at Tallahassee. Staffed largely by physicians who practice in the field of obstetrics, this educational exhibit of the American Medical Association drew wide public attention in its first North Florida appearance. Many questions from expectant parents visiting the exhibit were answered by the physicians in attendance. The physicians were assisted during the fair by members of the Woman's Auxiliary to the society and by members of the Florida Medical Association staff.

Many of the more than one million persons attending the huge Florida State Fair in Tampa visited the jointly sponsored Florida Medical Association-Hillsborough County Medical Association exhibit. On display for the duration of the fair, which was held January 29 through February 9, 1957, were the American Medical Association's two newest exhibits, entitled "We See" and "We Hear." The latter exhibit was seen for the first time in public in the United States. Thousands of persons, many of them winter visitors from all parts of North America, took advantage of the opportunity to test their visual perception and hearing ability, expertly guided by members of the Hillsborough County Medical Association. In charge of decorating the exhibit were members of the Woman's Auxiliary to the Hillsborough County Medical Association, who also assisted the physicians and staff members of the Florida Medical Association during the fair.

Orlando was the site of a second showing in Florida of the "We See" exhibit, sponsored by the Orange County Medical Society in the Cen-

The exhibit "Accidental Poisoning in Children" is shown at left as crowds attending the Pensacola Interstate Fair saw it recently. The exhibit was sponsored by the Escambia County Medical Society. At right are the two exhibits "We See" and "We Hear" as displayed at the Florida State Fair in Tampa under the joint sponsorship of the Florida Medical Association and the Hillsborough County Medical Association.

tral Florida Fair, February 18-23. Featured along with the exhibit were technicians from the Central Florida Blood Bank, who offered blood typing and Rh determination to the hundreds of persons who availed themselves of the opportunity to receive this important service. Physicians of the Orange County Medical Society were on hand to supervise the activities and to answer the questions of the many fair visitors. Subscriptions to Today's Health Magazine were made available during the fair by the members of the Woman's Auxiliary to the Orange County Medical Society, who also furnished the exhibit decorations.

The Pensacola exhibit was planned and supervised by Dr. Egbert V. Anderson, of Pensacola, Chairman of the Committee on Public Relations of the Escambia County Medical Society. Assisting was Mrs. Samuel B. D. Rhea, also of Pensacola, President of the Woman's Auxiliary to the Escambia County Medical Society. In charge of the North Florida Fair exhibit was Dr. Francis T. Holland, of Tallahassee, Chairman of the Committee on Public Relations of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society, assisted by Dr. Merritt R. Clements, also of Tallahassee. Mrs. Thomas J. Bixler, of Tallahassee, President of the Woman's Auxiliary to the society, supervised the Auxiliary preparations for the project.

Arrangements for the Florida State Fair exhibit were planned by Dr. Collin F. Baker Jr. and Dr. Warren T. Loftis Jr., both of Tampa, 1956 Chairman and 1957 Chairman, respectively, of the Public Service Committee of the Hillsborough County Medical Association. Mrs. William J. Lancaster, of Tampa, President of the Woman's Auxiliary to the Hillsborough County Medical Association, was in charge of decorating and other Auxiliary details.

Dr. Robert L. Tolle, of Orlando, Chairman of the Committee on Public Relations of the Orange County Medical Society, assisted by Dr. James A. McLeod, also of Orlando, directed the Central Florida Fair exhibit. In charge of the Today's Health Magazine display was Mrs. J. Arthur Ford, of Winter Park, Today's Health Chairman of the Woman's Auxiliary to the Orange County Medical Society.

The programs of the Specialty Societies, holding meetings concurrent with the Association's Annual Convention May 5-8 are scheduled for publication in the April issue of The Journal.

Florida Association of Blood Banks Meets in Miami Beach, May 10-12

The Florida Association of Blood Banks will hold its Eleventh Annual Meeting on Friday, Saturday and Sunday, May 10, 11 and 12, 1957, at the Golden Gate Hotel. The Golden Gate is located at 19400 Collins Avenue, Miami Beach, just a short distance from the Hollywood Beach Hotel.

The Directors of the Florida Association of Blood Banks selected these dates for their annual meeting since they follow immediately after the Florida Medical Association annual meeting, and the Golden Gate was chosen because of its proximity to the Hollywood Beach Hotel, in the hope that a sizeable number of the members of the Florida Medical Association will stay over for the Blood Bank Association meeting.

A program of widespread interest is being arranged and will be announced in a later issue of The Journal.

Anyone wishing information regarding reservations or accommodations for the Blood Bank Association meeting please write to J. M. Potts, Secretary, Florida Association of Blood Banks, 1851 Delaware Parkway, Miami.

STATE BOARD OF HEALTH

Good — But Not Enough

Florida has a superior record in immunizations against poliomyelitis, as compared with other states. It is estimated that 55 per cent of those under age 20, the group eligible to receive vaccine purchased at public expense, have received one or more injections and that 33 per cent have received two injections while only 12.4 per cent have received the full course of three injections. At its current rate of use, by April Florida will have used in nine months the amount of vaccine made available through federal funds for one year. Elsewhere the program lags. It is hoped that available funds may be reallocated according to demand and that Florida may continue to have vaccine available for distribution until the anticipated date of the termination of the federal program on June 30.

In 1954, the medical profession in two of our counties gave freely of their services in the field trials using vaccine provided by the National Foundation for Infantile Paralysis, inoculating first and second grade students as part of a

nationwide test of the efficacy of polio vaccine. The following year real enthusiasm was shown by the profession and by the public over the promising results reported, followed by dark pessimism with the evidence that cases followed inoculation with certain lots of the vaccine in some other areas of the country. Over a period of weeks the program was halted while the problems of manufacture and control were re-examined and evaluated with meticulous care. The evidence of late 1955 and 1956 has established with security the safety of the vaccine and is adding strong evidence that the full course of three doses of vaccine virtually removes the hazard of paralytic polio. Florida has yet to have one proved case of paralytic polio in a person with the three inoculations given as recommended. Hopeful evidence of this type is slowly accumulating for the country as a whole. It therefore seems tragic that only 12 per cent of the youngsters at the last estimate have received this relatively complete protection.

Knowledge alone has no value in the prevention of disease. To be effective the vaccine must be used. The supplies now stored in the refrigerators of manufacturers with expiration dates fast approaching, and with "RUSH" in large red letters on the shipping cartons, are not aiding in the prevention of paralytic polio. There is plenty of vaccine available through commercial channels to inoculate any person desiring it, regardless of age. The problem of getting this vaccine to people is ours — and that of our health agencies. How may individuals and families be encouraged to seek the protection which we can provide? How may we extend the coverage to older age groups — at least up to age 40?

The reaction of the public as a whole to this disease is well known. Spurred by fear of the crippling effects of this disease and stimulated further by an active voluntary health agency, the public will demand that paralytic polio be prevented. They may again place strong pressure on the county health departments to spearhead the administration of the vaccine. Our health departments do not wish to have the job done this way and they are ready to encourage the public to go to their own physicians for this preventive inoculation. They are in better position than private practitioners to publicize and promote the use of the vaccine. The private physicians, in turn, are better prepared to administer the vaccine, as proved in the county with the highest per cent of vaccinated persons where 90 per cent of the vaccine was administered by private physicians. The recent combined action of the Dade County Medical Association, the National Foundation for Infantile Paralysis and the Dade County Health Department, in attempting to immunize every susceptible person in Dade County, is to be commended and should serve as a guide to other communities.

This is the time for more effective cooperation by every county medical society with its county health department. Florida has made a good beginning in immunizing against polio, but what we have done is not enough. Let us together complete the job which was so successfully started and eliminate paralytic polio.

There follows a statement by the State Advisory Committee on Salk Vaccine, headed by Dr. Richard G. Skinner Jr.

Salk Vaccine Advisory Committee Urges Immunization

At a recent meeting The State Advisory Committee on Salk Vaccine discussed the request of the Hon. Charles Bennett for us to advise him on his desire to initiate legislation to increase the age limit of those eligible for federal vaccine.

In statistics available from the Florida State Board of Health it has been found that the second highest attack rate for polio occurs in the 25-29 year age group.

Studies made elsewhere have proved that patients immunized with polio vaccine can be carriers of the live virus, when exposed, the same as before being vaccinated although they themselves may be protected; therefore, it is essential that as many people as possible be immunized to eliminate the disease.

With these facts in mind, the Committee wired Mr. Bennett the following recommendations:

1. That the eligible age be extended to age 40 years.
2. That the federal program should end June 30, 1957 at the expiration of the present law.
3. That means should be instituted to transfer funds available so that the vaccine could be provided in areas where the demand was present and not allowed to go unexpended in areas where there was not much demand.

The Committee would like to go on record as urging all physicians to immunize as many people as possible, both children and adults, before the onset of the summer months and the traditional increase in polio.

LET US WIPE OUT POLIO!

Respectfully submitted,

State Advisory Committee on Salk Vaccine
Richard G. Skinner Jr., M.D., Chairman
John D. Milton, M.D.
Warren W. Quillian, M.D.
Wilson T. Sowder, M.D.
Mr. R. Q. Richards

OTHERS ARE SAYING

In Lighter Vein

Everyone has noted them sitting behind big desks, or "in conference" behind closely guarded doors, well dressed, carefully groomed, important, with or without briefcases—the executives. In recent years more and more doctors are moving into this class all over the country. One sees them, one recognizes them for what they are but —what do they do? What are their functions?

Dr. Harry Levinson of the Menninger Foundation seems to have made a contribution to this subject which we hasten to pass on for the benefit of present and future executives in medicine. "As nearly everyone knows," he writes, "an executive has practically nothing to do, except to decide what is to be done; to tell someone to do it; to listen to reasons why it should not be done, why it should be done by someone else, or why it should be done in a different way; to follow up to see if the thing has been done; to discover that it has been done incorrectly; to point out how it should have been done; to conclude that as long as it has been done, it may as well be left where it is; to wonder if it is not time to get rid of a person who cannot do a thing right; to reflect that he probably has a wife and a large family and that certainly any successor would be just as bad, and maybe worse; to consider how much simpler and better the thing would have been done if one had done it oneself in the first place; to reflect sadly that one could have done it in twenty minutes, and, as things turned out, one has to spend two days to find out why it has taken three weeks for someone else to do it wrong."[1]

Let those who contemplate medical administration as a full or part-time career preserve this excerpt for reference.

[1]Excerpted from American Management Association Personnel Series No. 167.

—*New York State Journal of Medicine*
January 1, 1957

California Career Opportunities for Physicians and Psychiatrists

Employment available as a result of interview *only*.
Wide choice of assignments in State hospitals, outpatient clinics, juvenile and adult correctional facilities and a veterans home.
Annual merit salary increases, five-day, forty-hour week, three week vacation and eleven paid holidays yearly. Sick leave and retirement annuities.
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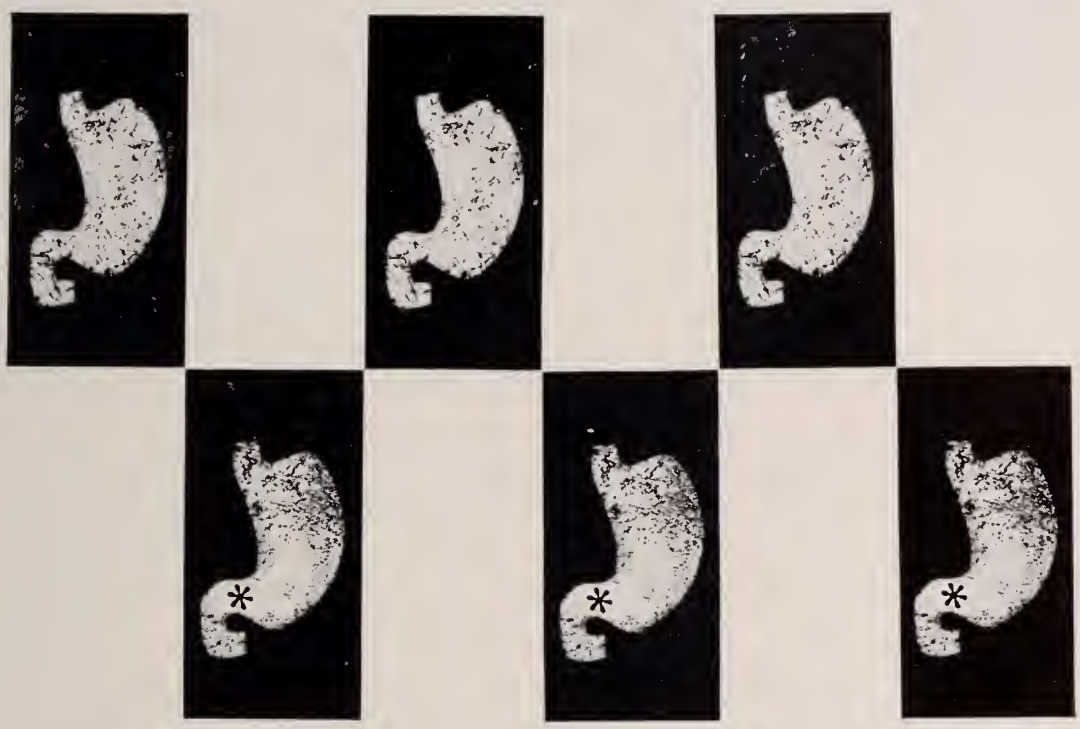
Candidates must be United States citizens and in possession of, or eligible for California license.
Write:
Medical Recruitment Unit, Box A.
State Personnel Board
801 Capitol Avenue
Sacramento 14, California

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Barker, Arthur J. Jr., St. Petersburg
Brown, Glenn C., Haines City
Buckley, Lawrence R., St. Petersburg
Burns, James P. Jr., Clearwater
Davis, Albert J. Jr., St. Petersburg
Davis, Janis G., St. Petersburg
Edgerton, Norman B., Palatka
Garrett, Spencer R., Lakeland
Geathers, Edward W. (Col.) Winter Haven
Hays, Glenn B., Tarpon Springs
Herman, August C., Lakeland
Inman, Charles W., Lakeland
Jeffrey, William G., St. Petersburg
Kreider, Everette F. Jr., St. Petersburg
Lasley, Charles H., Clearwater
Lord, Kurtland H., Dunedin
Lowenstein, Bertrand F., Miami
Mix, George H., Lakeland
Pennington, Townsend S., Lake Wales
Simmons, Frederic R., Daytona Beach
Solomon, Henry D. Jr., St. Petersburg
Stevenson, Robert L., Daytona Beach
Tanner, Paul A., Auburndale
Thompson, John M., St. Petersburg
Waite, Ellsworth F., Daytona Beach
Wilkerson, Ellis W. III, St. Petersburg

TRUE ANTICHOLINERGIC ACTION



Pro-Banthīne® Inhibits Excess Parasympathetic Stimuli in Peptic Ulcer

Medical literature now contains more than 500 references to the beneficial role of Pro-Banthīne Bromide (brand of propantheline bromide) and Banthīne® Bromide (brand of methantheline bromide) as evidenced by a marked healing response of peptic ulcers. Rapid symptomatic improvement, particularly with reference to pain relief, is followed by roentgenographic demonstration of crater filling.

The therapeutic action of Pro-Banthīne in decreasing hypermotility and hyperacidity, together with the remarkable early subjective benefit, is a desired approach in the management of ulcers.

The initial suggested dosage is one tablet, 15 mg., with meals and two tablets at bedtime. An increased dosage may be necessary for severe manifestations and then two or more tablets four times a day may be indicated. G. D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

SEARLE

Erythromycin in Treating Pneumonia

A 27-year-old man, a chronic alcoholic, was admitted with a history of an alcoholic spree followed by a cough, greenish sputum and chills and fever.

Physical examination showed a temperature of 104 F. and indicated pneumonia in the right lower lobe. This was confirmed by X-ray. The sputum revealed gram-positive diplococci and blood culture subsequently grew Type VII pneumococci.

The patient was treated with erythromycin, 300 mg. every six hours per os. His temperature dropped to normal by 48 hours and X-ray of the chest revealed considerable clearing by the fourth hospital day. After 10 days hospitalization, the patient was fit for discharge.[1]

First Antibiotics Symposium, we reported the successful treatment with thromycin of *H. influenzae* pneumonia and bacteremia. A second patient with *H. influenzae* pneumonia and bacteremia had a clinical course almost identical to the one previously reported, with cure obtained by treatment with 500 mg. of erythromycin per os every four hours for 14 days.

Of these 132 patients with bacterial

"Highly Effective in Pneumonia"

In one investigation, 75 adult patients with bacterial pneumonia were treated with erythromycin. In his summary, the clinician reported: "It is concluded that erythromycin is highly effective in the treatment of pneumonia due to gram-positive bacteria."[2]

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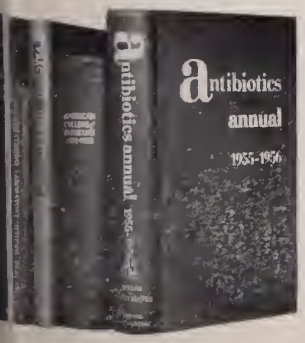

1. Romansky, M.J., et al., Antibiotics Annual 1955-1956, p. 48.
2. Waddington, W. S., Maple, F. C., and Kirby, W. M. M., A.M.A. Archives of Internal Medicine, 1954, p. 556.

701051

The Southeastern Surgical Congress, St. Petersburg Assembly Twenty-Fifth Annual Meeting, April 1-4, 1957 Vinoy Park Hotel

SPEAKERS

JOHN H. GIBBON, JR., M.D., (Guest), Philadelphia, Pa.
Hiatal Hernia

GORDON P. MCNEER, M.D., (Guest), New York, N. Y.
End Results and Prognosis in Gastric Cancer

O. H. BEAHRS, M.D., (Guest), Rochester, Minn.
Parotid Tumors and Their Surgical Management

T. B. PATTON, M.D., Birmingham, Ala.
Problems of Portal Hypertension

MURRAY M. COPELAND, M.D. and CHARLES F. GESCHICKTER, M.D., Washington, D. C.
An Evaluation of Cystic Tumors of the Neck

HAWLEY H. SEILER, M.D., Tampa, Fla.
The Surgical Treatment of Pectus Excavatum

J. O. MORGAN, M.D., Gadsden, Ala.
Presidential Address

EDWARD B. MERSCH, M.D., Covington, Ky.
Concurrent Liver Biopsy and Cholecystectomy

ROWENA SPENCER, M.D., New Orleans, La.
The Recognition and Treatment of Surgical Lesions in the New Born

WILLIAM J. RYSANEK, JR., M.D., Baltimore, Md.
Presacral Sympathectomies

EUGENE A. BUSH, M.D., Laurel, Miss.
Some Anatomical Observation in the Inguinal Region

KEITH S. GRIMSON, M.D., Durham, N. C.
Peripheral Vascular Disease

TURMAN T. WALLACE, M.D., Spartanburg, S. C.
A New External Cutter in Varicose Vein Surgery

SAMUEL F. MARSHALL, M.D., (Guest), Boston, Mass.
Primary Carcinoma of the Gallbladder

ROBERT R. LINTON, M.D., (Guest), Brookline, Mass.
Bleeding Esophageal Varices, the Emergency and Definitive Treatment

SHERMAN A. EGER, M.D., (Guest), Philadelphia, Pa.
An Improved Method of Adrenal Denervation for Essential Hypertension

CHARLES C. TRABUE IV, M.D., Nashville, Tenn.
Choledochotomy and Cholangiography

DAVID M. HUME, M.D., Richmond, Va.
Electrolytes and Fluid Balance

A. KYLE BUSH, M.D., Philippi, W. Va.
Surgical Transplantation of Tumors

JOHN M. SLAUGHTER, M.D., Fairfield, Ala.
Ano-Rectal Carcinoma Associated with Neglected Fistulae in Ano

G. W. MORSE, M.D., Pensacola, Fla.
Congenital Tracheo-Esophageal Fistula Without Esophageal Atresia

SAM WILKINS, JR., M.D., Emory University, Ga.
Management of Melanoma

DELMAS M. CLARDY, M.D., Hopkinsville, Ky.
A Less Painful Hemorrhoidectomy

HOWARD J. TATUM, M.D., New Orleans, La.
Low Salt Syndrome

OTTO C. BRANTIGAN, M.D., Baltimore, Md.
The Surgical Treatment of Pulmonary Emphysema

WILLIAM FRANCIS MARTIN, M.D., Charlotte, N. C.
An Operative Procedure for Pilonidal Cysts and Sinus

RALPH F. BOWERS, M.D., Memphis, Tenn.
The Present Status of the Treatment for Malignancy of the Stomach

WILLIAM A. JOHNS, M.D., Richmond, Va.
Ventral Hernia, a Method of Repair

B. MARDEN BLACK, M.D., (Guest), Rochester, Minn.
Present Status of Surgery in the Treatment of Chronic Ulcerative Colitis

HENRY DOUBILET, M.D., (Guest), New York, N. Y.
The Treatment of Pancreatitis by Sphincterotomy

JOHN M. DORSEY, M.D., (Guest), Evanston, Ill.
The Indications and Technic of Sternum Splitting Approach to the Thorax

FREDERICK W. COOPER, JR., Emory University, Ga.
Treatment of Insidious Thrombosis of the Terminal Aorta

FRANK LAMONT MELENEY, M.D., Miami, Fla.
Ways and Means of Preventing or Minimizing Surgical Infections

HENRY S. COLLIER, M.D., Louisville, Ky.
Technique of Cholecystectomy and Common Duct Exploration

J. C. THOROUGHMAN, M.D., Atlanta, Ga.
Spontaneous Perforation of Pseudocysts of the Pancreas

HUGH B. LYNN, M.D., Louisville, Ky.
Obstruction of the Ileum in the Newborn Infant

THURSTON RAY ADAMS, M.D., Baltimore, Md.
Gastrojejunocolic Fistula

J. KEITH CROMER, M.D., Washington, D. C.
The Role of Surgery in the Management of the Late Vaginal Recurrence Following Irradiation and/or Surgical Treatment of Cervix Cancer

PAUL S. PUTZKI, M.D., Washington, D. C.
Surgical Complications in Pregnancy

LLOYD G. LEWIS, M.D., Washington, D. C.
Traumatic Injuries of the Lower Urinary Tract

SPEAKERS

JAMES G. LYERLY, M.D., Jacksonville, Fla.
The Management of Compound Depressed Fractures of the Skull with Special Reference to the Closure of the Cranial Defect

EUGENE L. JEWETT, M.D., Orlando, Fla.
An Evaluation of a New Hip Prosthesis Used in Forty-Two Patients Over a Six Year Period

ROBERT F. HAGERTY, M.D., Charleston, S. C.
Hypospadias

HOKE WAMMOCK, M.D., Augusta, Ga. and C. MARTIN RHODE, M.D., Augusta, Ga.
Pitfalls in the Managements of Cancer of the Head and Neck

J. M. EMMETT, M.D., Clifton Forge, Va.
Gastric Resections, a Definitive Treatment for Perforated Peptic Ulcer

LAWRENCE E. GORDON, JR., M.D., Johnson City, Tenn.
Genital Cytology as an Adjunct in the Diagnosis and Management of Stage O Cervical Carcinoma in Private Practice

ADDISON G. BRENIZER, JR., M.D., Charlotte, N. C.
Some Aspects of Secondary Thyroidectomy

B. B. RICHMOND, M.D., Beckley, W. Va.
Urology in the Coal Fields

GEORGE F. ARCHER, M.D., Greenville, Miss.
The Problem of the Bleeding Nipple Associated with an Otherwise Normal Breast

H. REICHARD KAHLE, M.D., New Orleans, La.
The Surgical Treatment of Aneurysms

CLAUDE E. WELCH, M.D., (Guest), Boston, Mass.
Management of Massive Upper Gastrointestinal Hemorrhage

THOMAS G. BAFFES, M.D., (Guest), Skokie, Ill.
Current Status of the Surgery of Transposition of the Great Vessels

J. RICHARD AMERSON, M.D., Atlanta, Ga.
Scientific Paper Award Contest Winner
Acute Gastroduodenal Perforation—Study of 381 Patients

PANEL DISCUSSIONS

No. I Problems in Anesthesia
WALTER JONES, M.D., Miami, Fla., Moderator

Discussion:
1. EVERETT H. BAKER, M.D., Louisville, Ky.
Choice of Anesthetic Agents

2. Francis H. Langley, M.D., St. Petersburg, Fla.
   Problems of Anesthesia in Geriatics
3. George Clauer, M.D., New Orleans, La.
   Cooperation Between Surgeons and Anesthetists, Particularly in Poor Risk Patients

No. II Electrolyte and Fluid Balance
Champ Lyons, M.D., Birmingham, Ala., Moderator

Discussion:
1. David Hume, M.D., Richmond, Va.
   do[illegible] influen[illegible]
2. Paul P. Salter, M.D., Birmingham, Ala.
   Transcapillary Shifts
3. Champ Lyons, M.D., Birmingham, Ala.
   Transcellular Shifts

No. III Pancreatitis
Howard Mahorner, M.D., New Orleans, La., Moderator

Discussion:
1. Ralph Bowers, M.D., Memphis, Tenn.
   The Causes of Pancreatitis
2. John M. Dorsey, M.D., Evanston, Ill.
   The Clinical and Surgical Recognition of Pancreatitis
3. Henry Doubilet, M.D., New York, N. Y.
   The Treatment of Pancreatitis

No. IV The Impact of Religion on the Surgeon
A. H. Letton, M.D., Atlanta, Ga., Moderator

Discussion:
1. E. Augustus Verdery, Th.D., Chaplain, Baptist Hospital, Atlanta, Ga.
2. R. L. Sanders, M.D., Memphis, Tenn.
3. Gilbert F. Douglas, M.D., Birmingham, Ala.
4. Paul R. Hortin, D.D., Minister of Christ Church, St. Petersburg, Fla.

Hotel Rates (American Plan). Rates at the Vinoy Park and Soreno Hotels for guests during the St. Petersburg Assembly will be $14.00 daily per person for double and $18.00 daily for single occupancy of rooms.

Please make reservations with the manager of the Vinoy Park Hotel, St. Petersburg, Fla.

For information write to

B. T. Beasley, M.D., Secretary-Director General
The Southeastern Surgical Congress
701 Hurt Building, Atlanta 3, Ga.

CLASSIFIED

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

WANTED: Physician with Florida license. Interest in Physical Medicine and Geriatrics. State qualifications in writing. The Miami-Battle Creek, Miami Springs, Fla.

PHYSICIAN WANTED: General Practitioner to associate with a well established medical clinic in Miami area. Basis of percentage, salary or rental. Salary open, depending on experience and training. Give complete personal and professional data in first letter. Florida license required. Write 69-206, P. O. Box 2411, Jacksonville, Fla.

FOR SALE: 20 MA Mattern upright combination fluoroscope and X-Ray with all accessories including timer, developing tank, cassette and wall cassette holder, film hangers, lead gloves and apron. Cost $1,500 new 3 years ago—sell for $800. Write A. J. Kelly, M.D., 1213 West Hillsborough Ave., Tampa. Phone 3-7341

OPHTHALMOLOGIST: Board eligible, Category IV. Age 32, married. Florida license. Available July 1957. Interested in promising location or association. Write 69-211, P.O. Box 2411, Jacksonville, Fla.

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EYE PHYSICIAN: With 20 years experience desires position or association with South Florida Ophthalmologist. Write 69-214, P. O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER: in South Florida desires assistant. Good hospital privileges. Favorable percentage arrangement with guaranteed minimum income. Must be male, graduate of grade A United States or Canadian school. Willing and able to do full general practice. Write 69-215, P. O. Box 2411, Jacksonville, Fla.

BIRTHS AND DEATHS

Births

Dr. and Mrs. J. Champneys Taylor, of Jacksonville, announce the birth of a son, Reid de Jarnette, on January 6, 1957.

Dr. and Mrs. Jonathan H. Wood, of Jacksonville, announce the birth of a daughter, Bettie Wright, on December 25, 1956.

Deaths — Members

Chandler, Gail E., Miami	December 15, 1956
Garcia, Louis J., Tampa	December 22, 1956
Light, Samuel D. W., Miami	October 16, 1956
Schnauss, Wm. R., Jacksonville	December 22, 1956
Thompson, Rollin D., Coral Gables	November 25, 1956
Thurston, Leon M., Gulfport	December 4, 1956
Wilkins, Charlotte K., North Miami	November 4, 1956
Williams, Carl A., Noank, Conn.	December 24, 1956

Deaths — Other Doctors

Farmer, Charles H., Macon, Ga.	June 23, 1956
Massenburg, George Y., Macon, Ga.	September 1, 1956
Weems, George E., Apalachicola	November 29, 1956
Dorland, William A. N., Tampa	September 11, 1956
Fisher, Judson C., Orlando	August 25, 1956
Winston, Benjamin, Gainesville	July 13, 1956
Herlong, Mark B., Starke	January 19, 1957
Meneray, W. Eugene, Gadsden, Ala.	November 6, 1956
Stuteville, Ethel, Oakland, Calif.	October 11, 1956

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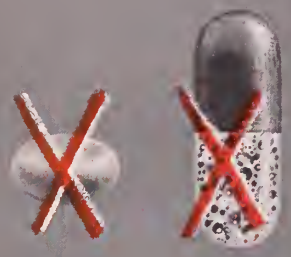

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STATE NEWS ITEMS

The Twenty-Fifth Annual Assembly of the Southeastern Surgical Congress is being held Monday through Thursday, April 1-4, in St. Petersburg. The Vinoy Park Hotel is headquarters.

This will be the fourth meeting of the Congress in Florida. The first one was in March, 1935, at Jacksonville. The next two were at Hollywood in 1948 and 1951. Dr. Joseph S. Stewart, of Miami, was elected president during the meeting in 1951.

Among the present officers of the Congress are Dr. Frank D. Gray, of Orlando, vice president, and Dr. Julius C. Davis, of Quincy, councilor for Florida. Dr. J. O. Morgan, of Gadsden, Ala., is president.

There are 53 scientific addresses on the program for the St. Petersburg meeting. In addition there are four panel discussions. Speakers have been selected from all parts of the United States.

Seven of the speakers are from Florida. Dr. Francis H. Langley, of St. Petersburg, president of the Florida Medical Association, is a member of the panel which is to present a discussion of "Problems in Anesthesia." Dr. Walter C. Jones, of Miami, will serve as moderator of the panel.

Dr. Hawley H. Seiler, of Tampa, is scheduled to discuss "The Surgical Treatment of Pectus Excavatum," and Dr. George W. Morse, of Pensacola, "Congenital Tracheo-Esophageal Fistula Without Esophageal Atresia."

Dr. Frank L. Meleney, of Miami, will address the Assembly on the subject "Ways and Means of Preventing or Minimizing Surgical Infections." Dr. James G. Lyerly, of Jacksonville, has chosen for his topic "The Management of Compound Depressed Fractures of the Skull with Special Reference to the Closure of the Cranial Defect."

Dr. Eugene L. Jewett, of Orlando, whose address follows closely after that of Dr. Lyerly, will discuss "An Evaluation of a New Hip Prosthesis Used in Forty-Two Patients Over a Six Year Period."

A complete list of speakers and the titles of their addresses may be found elsewhere in this issue of The Journal.

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Hotel reservations for the Assembly should be made with the Vinoy Park Hotel or the Soreno Hotel. Information concerning the Assembly may be obtained from Dr. B. T. Beasley, Secretary-Director General, The Southeastern Surgical Congress, 701 Hurt Building, Atlanta 3, Ga.

Dr. Elwyn Evans of Orlando has been made a director of the American Heart Association.

Several Florida physicians were on the program for the Diabetes and Health of the Aged Seminar held recently at Tampa. Among them were Dr. Lorenzo L. Parks of Jacksonville; Dr. Clarence L. Brumback of West Palm Beach; Dr. Edward R. Smith of Jacksonville; Dr. Chester L. Nayfield of Lakeland, and Dr. H. Phillip Hampton of Tampa.

Dr. Alvan G. Foraker of Jacksonville has been awarded a research grant of $5,100 for continuation of an investigation into "Cytochemical and Cytomorphological Orientation of Intraepithelial Carcinoma of the Cervix Uteri."

The following refresher courses will be given at The Children's Hospital of Philadelphia in May and June, 1957: "Pediatric Advances for Pediatricians and General Practitioners," May 27-31, tuition $110; "Practical Pediatric Hematology," June 3-5, tuition $75, and "Blood Group Incompatibilities and Erythroblastosis Fetalis," June 6-7, tuition $50. Inquiries should be addressed to Irving J. Wolman, M.D., Children's Hospital of Philadelphia, 1740 Bainbridge St., Philadelphia 46, Pa.

Dr. Manuel A. Schofman of Miami has been elected president of the Greater Miami Eye, Ear, Nose and Throat Society. Dr. Max M. Kulvin has been chosen vice president, and Dr. James H. Mendel Jr. secretary-treasurer. The Society meets quarterly (March, May, October and December) on the second Thursday of the month.

Dr. Hawley H. Seiler of Tampa and Dr. Meredith F. Campbell of Miami will deliver scientific papers at the Second Inter-American Medical Convention being held April 3-5 at Panama City, Republic of Panama.

Dr. Seiler is to discuss "Surgery of Pulmonary Lesions Other Than Cancer" and Dr. Campbell "Obstructive Uropathies in Childhood."

(Continued on page 922)

NEW...

Each Multiple Compressed Tablet of Meprolone provides the inseparable antiarthritic, antirheumatic benefits of:

1. *Prednisolone buffered*—the newest and most potent of the "predni-steroids" for prompt relief of joint pain and arrest of the destructive inflammatory process.

2. *Meprobamate*—the newest and safest of the muscle-relaxant tranquilizers for profound relaxation of skeletal muscle in spasm.

Tolerance to this combination is good because there is little likelihood of sodium retention, potassium depletion or gastric distress with buffered prednisolone, and meprobamate rarely produces significant side effects in therapeutic dosage.

An additional important therapeutic benefit, often overlooked, stems from the tranquilizing action of meprobamate. This component of Meprolone relieves mental tension and anxiety so often manifest in arthritics, making them more amenable to other rehabilitation measures.

INDICATIONS: A wide variety of conditions, in which four symptoms predominate: *a*) inflammation *b*) muscle spasm *c*) anxiety and tension *d*) discomfort and disability; i.e., rheumatoid arthritis, rheumatoid spondylitis (Marie-Strümpell disease), Still's disease, psoriatic arthritis, osteoarthritis, bursitis, synovitis, tenosynovitis, myos sitis, fibromyositis, neuritis, acute and chronic pain, acute and chronic primary and secondary and torticollis, intractable asthma, respiratory allergic and inflammatory eye and skin disorders tenance therapy in disseminated lupus eryth periarteritis nodosa, dermatomyositis and scle

Therapeutic benefits of MEPROLONE compared with traditional

	relieves pain	suppresses inflammation	relaxes muscle	eases anxiety
Salicylates	✓	✓		
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MEPROLONE	✓	✓	✓	✓

1. Meprobamate is the only tranquil muscle-relaxan

SUPPLIED: Multiple Compressed Tablets in 100 in two formulas as follows: Meprolone-1 of prednisolone, 200 mg. of meprobamate and dried aluminum hydroxide gel. Meprolone-2- 2.0 mg. of prednisolone in the same formula.

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(Continued from page 919)

The Convention is being sponsored by the Medical Society of the Isthmian Canal Zone of which Colonel Charles O. Bruce, chief health officer of the Panama Canal Company, is president. Colonel Bruce will act as keynote speaker at the invocation ceremonies which will include addresses by the President of the Republic of Panama and by the Governor of the Panama Canal Zone.

Dr. Howard L. Reese announces the opening of offices for the practice of general and thoracic surgery at 1998 5th Avenue North, St. Petersburg.

At a recent meeting of the Southern Thoracic Surgical Association held at Miami Beach, the following officers were elected: Dr. Duane Carr, Memphis, Tenn., president; Dr. DeWitt C. Daughtry, Miami, vice president, and Dr. Hawley H. Seiler, Tampa, secretary-treasurer.

Dr. George T. Harrell of Gainesville has been appointed to the Southern Regional Council on Mental Health Training and Research by Governor LeRoy Collins.

The Graduate Instructional Course of the American College of Allergists is being held March 17-19 in the Palmer House at Chicago. The Thirteenth Annual Meeting of the College begins the day following termination of the course and ends March 22. Fee for the course is $50. It meets American Academy of General Practice standards of postgraduate study for Category II credit.

Dr. Sidney Halpern of Jacksonville has been elected president of the Duval County Chapter of the Florida Academy of General Practice. Dr. S. James Beale also of Jacksonville is vice president.

Health Services Course Number Two of the Federal Civil Defense Administration Staff College is being held April 15-19 in Atlanta. Probable headquarters for the Course is the Academy of Medicine, 875 West Peachtree Street. Dr. Charles E. Dowman, A.M.A. representative for Region Three of the Health Services Advisory Committee, announcing the Course, stated registration would be limited to 200. Physicians desiring to attend should contact Dr. Lester Petrie, Deputy Director, Georgia Civil Defense Health Services, Department of Public Health, Atlanta.

Immediately following the Course, the Implementation Committee of the Health Services. FCDA Region Three, will meet from noon April 19 to noon April 20 in VA Hospital No. 48, 5998 Peachtree Road, N.E.

Mrs. E. Quackenbush of Fort Lauderdale has been made executive secretary of the Broward County Medical Association. In addition to these duties, she also is assistant to the editor of the Association's official publication, The Bulletin.

Better late than never believes one doctor in Florida, at least in the matter of expressing his opinion in favor of social security coverage for physicians.

In January, 1954, the Committee on Legislation and Public Policy of the Florida Medical Association mailed each Association member a letter with return postcard enclosed in an effort to determine the opinions regarding social security coverage for physicians. Throughout the early months of 1954, the postcards were returned. Finally the survey was completed. Recently one of the cards turned up in the day's mail delivered at the Association's headquarters. It was postmarked Dec. 31, 1956, at Ormond Beach, almost three years from the day it was sent out.

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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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COMPONENT SOCIETY NOTES

Alachua

Dr. Glenn O. Summerlin, of Gainesville, has been installed as president of the Alachua County Medical Society. Dr. G. Leonard Emmel has been chosen president-elect; Dr. George H. Putnam, vice president, and Dr. Eugene H. Cummings, secretary-treasurer. Drs. Emmel, Putnam and Cummings are also from Gainesville.

Bay

Dr. John J. Benton has been elected president of the Bay County Medical Society. Chosen to serve with Dr. Benton for the year 1957 are Dr. William C. Fontaine, vice president; Dr. Lloyd B. Harrison Jr., secretary, and Dr. James A. Poyner, treasurer. All the physicians are from Panama City.

Brevard

Dr. Myron L. Habeggar, of Rockledge, was elected president of the Brevard County Medical Society at the recent annual meeting. Dr. Jack T. Bechtel, of Eau Gallie, was chosen vice president, and Dr. Louis C. Jensen, of Cocoa, secretary.

Dr. James F. Speers, of Titusville, Brevard county health officer, was principal speaker at the Society's first meeting of the new year held at Cocoa. He discussed the medical care program for indigents in the county.

Broward

Dr. Walter J. Glenn Jr., of Fort Lauderdale, has been installed as president of the Broward County Medical Association. Chosen president-elect at the recent annual meeting was Dr. Russell R. Hippensteel, of Hollywood. Other officers are Dr. Miles J. Bielek, vice president; Dr. Garland M. Johnson, secretary, and Dr. James F. Berry, treasurer. All are from Fort Lauderdale.

Collier

Dr. James A. Craig has been installed as president of the newly formed Collier County Medical Society. Serving with Dr. Craig for the year 1957 will be Dr. Reidar Trygstad as vice president, Dr. Loral F. Gwaltney as treasurer, and Dr. Ethel H. Trygstad as secretary. All are from Naples.

Dr. Francis H. Langley, of St. Petersburg, president of the Florida Medical Association, attended the Society's first meeting and presented the charter from the Association.

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Columbia

Dr. Thomas H. Bates has been reelected president of the Columbia County Medical Society. Dr. Laurie J. Arnold Jr. replaces Dr. Clifton J. York as secretary-treasurer, and the new vice president is Dr. Robert M. Sasso. The officers are from Lake City.

Dade

Dr. Walter W. Sackett Jr. has been installed as president of the Dade County Medical Association for the year 1957. Dr. Sackett is from Miami. The new president-elect is Dr. Nelson Zivitz, of Miami Beach.

Dr. Robert P. Keiser, of Coral Gables, has been elected vice president, and Dr. Franklin J. Evans, also from Coral Gables, has been chosen treasurer. Dr. Vincent P. Corso, of Miami, remains secretary.

DeSoto-Hardee-Highlands-Glades

Dr. Godfrey L. Beaumont is the new president of the DeSoto-Hardee-Highlands-Glades County Medical Society. Chosen at the recent annual meeting to serve with Dr. Beaumont were Dr. Lee Burley, as vice president, and Dr. Theodore W. Weeks Jr., as secretary-treasurer. All the physicians are from Sebring.

Duval

Dr. Leo M. Wachtel has been installed president of the Duval County Medical Society. Dr. Ashbel C. Williams, chosen president-elect at the recent annual meeting, will succeed Dr. Wachtel next year. Dr. J. Champneys Taylor has been elected vice president. Dr. Sidney Stillman, treasurer, and Dr. Charles F. McCrory, secretary, were reelected. All are from Jacksonville.

Staff members of the U.S. Naval Hospital at Jacksonville presented the program for the Society's February meeting. F. T. Norris, Capt. (MC), discussed "Loefflers Syndrome," P. D. Cronemiller, Cdr. (MC), and R. J. Fitzgibbons, Cdr. (MC), "Management of Empyema of Chest," and H. G. K. Faaland, Cdr. (MC), "Hysterosalpingography at a Naval Hospital."

Escambia

Dr. Paul F. Baranco has succeeded Dr. Gretchen V. Squires as president of the Escambia County Medical Society. Voted president-elect was Dr. Joseph W. Douglas, and Dr. Alpheus T. Kennedy has been elected vice president. The secretary, Dr. Pascal G. Batson Jr., has been reelected. All the officers are from Pensacola.

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Franklin-Gulf

Dr. Photis J. Nichols, of Apalachicola, has been elevated from secretary to president of the Franklin-Gulf County Medical Society. Dr. William F. Wager, of Port St. Joe, is the new secretary.

Hillsborough

Dr. Madison R. Pope, of Plant City, has been installed president of the Hillsborough County Medical Association succeeding Dr. James N. Patterson. Dr. Wesley W. Wilson has been chosen president-elect, Dr. Thomas F. Nelson, vice president, and Dr. Marvin B. Miller, treasurer. Dr. James A. Winslow Jr. has been reelected secretary. The physicians are from Tampa.

Indian River

Dr. Walter W. McCorkle, of Vero Beach, is the new president of the Indian River County Medical Society. Chosen to serve with Dr. McCorkle for the current year are Dr. B. Bowman Guerin, vice president, and Dr. Enoch J. Vann Jr., secretary-treasurer. Drs. Guerin and Vann are also from Vero Beach.

Jackson-Calhoun

Dr. William W. Richardson, of Graceville, has succeeded Dr. Richard H. Schultz as president of the Jackson-Calhoun County Medical Society. Dr. Albert E. McQuagge, of Marianna, will serve with Dr. Richardson this year as vice president. Dr. Francis M. Watson has been reelected secretary-treasurer.

Lake

Dr. Fred A. Vincenti, of Mount Dora, has been elected president of the Lake County Medical Society. Chosen at the recent annual meeting to serve with Dr. Vincenti this year were Dr. William K. Smith, of Clermont, vice president, and Dr. J. Basil Hall, of Tavares, secretary-treasurer.

Dr. James D. Moody, of Orlando, was principal speaker at the Society's January meeting. His subject was "Aortic Resection and Bridging of Vascular Defects." Kodachrome slides were used to illustrate some of the cardiovascular surgery and homografts and plastic prosthesis were exhibited. A film in color produced by Dr. Moody and Dr. James A. McLeod depicting repairs of aortic defect was also shown.

Lee-Charlotte-Hendry

Dr. James L. Bradley, of Fort Myers, has been elected president of the Lee-Charlotte-Hendry County Medical Society. Dr. Joseph L.

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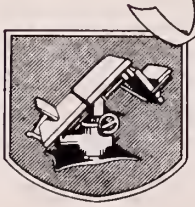

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*Geiger, E.: Digestion, Absorption and Metabolism of Protein, in Wohl, M. G., and Goodhart, R. S.: Modern Nutrition in Health and Disease, Philadelphia, Lea & Febiger, 1955, pp. 98-143.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

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Selden has been elected vice president, and Dr. George D. Hopkins II has been reelected secretary-treasurer. Both Drs. Selden and Hopkins are from Fort Myers.

Leon-Gadsen-Liberty-Wakulla-Jefferson

Dr. George S. Palmer, of Tallahassee, has been elected president of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society to succeed Dr. Robert H. Mickler. Dr. Nelson H. Kraeft, also of Tallahassee, has been elected secretary to succeed Dr. Odis G. Kendrick Jr.

Madison

Dr. Julian M. DuRant, of Madison, has been elected president of the Madison County Medical Society. Serving with Dr. DuRant this year as secretary will be Dr. A. Franklin Harrison, also of Madison.

Manatee

Dr. Joseph A. Gibson, of Bradenton, has begun serving as president of the Manatee County Medical Society following his election at the Society's recent annual meeting. Elected to serve with Dr. Gibson were Dr. Joseph B. Ganey, of Bradenton, vice president, and Dr. Warren G. Darty, of Palmetto, secretary-treasurer.

Marion

Dr. John D. Lindner has been elected president of the Marion County Medical Society for the year 1957, and Dr. Herbert M. Webb Jr. vice president. Dr. Robert L. Gibson will continue to serve as secretary-treasurer. The officers are from Ocala.

Monroe

Dr. Robert W. Reid has been elected president of the Monroe County Medical Society to succeed Dr. Allen Shepard. Serving with Dr. Reid for the year 1957 will be Dr. Charles W. Morrison, vice president, and Dr. Joseph J. Scarlet, secretary-treasurer. All are from Key West.

Nassau

Dr. Benjamin F. Dickins, of Fernandina Beach, has been reelected president of the Nassau County Medical Society. Dr. David D. Bennett, of Callahan, remains secretary-treasurer, and the vice president is Dr. Cecil B. Brewton, also of Fernandina Beach.

Orange

Dr. Frank J. Pyle, of Orlando, has been installed as president of the Orange County Med-

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1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954

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ical Society. The installation ceremony took place at the recent annual meeting during which Dr. Robert E. Zellner, also of Orlando, was chosen president-elect.

Dr. Morton Levy was elected vice president; Dr. Charles R. Sias treasurer, and Dr. W. Ansell Derrick was reelected secretary. Drs. Levy, Sias and Derrick are from Orlando.

The regular meeting of the Society was held January 16. At this time, in addition to the regular business before the Society, a demonstration of the indoctrination course was given. A recent member sat as the subject of the demonstration so that other members could observe the course that is given.

Palm Beach

Dr. Edward W. Wood, of Lake Worth, has been installed president of the Palm Beach County Medical Society for the year 1957.

At the recent annual meeting, Dr. W. Lawson Shackelford, of West Palm Beach, was chosen president-elect; Dr. S. Richard Ombres, vice president; Dr. Robert Y. Wheelihan, secretary, and Dr. Fred E. Manulis, treasurer. Dr. Ombres and Dr. Manulis are from West Palm Beach. Dr. Wheelihan is from Riviera Beach.

Pasco-Hernando-Citrus

Dr. Frank Y. Robson, of New Port Richey, has been elected president of the Pasco-Hernando-Citrus County Medical Society. Dr. Richard A. Henry, of Brooksville, and Dr. Jere W. Kirkpatrick, of Inverness, have been elected vice presidents, and Dr. W. Wardlaw Jones, of Dade City, has been reelected secretary-treasurer.

Pinellas

Dr. John R. Neefe, of St. Petersburg, was principal speaker for the February meeting of the Pinellas County Medical Society held at Madeira Beach. The title of his address was "Problems and Progress in Hepatitis." The program was under the direction of Dr. William R. Tench.

Polk

Dr. John P. Tomlinson Jr., of Lake Wales, has been installed as president of the Polk County Medical Association.

Voted president-elect at the recent annual meeting was Dr. Marion W. Hester, of Lakeland.

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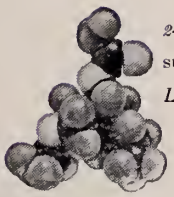

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Serving this year with Dr. Tomlinson are Dr. John H. Miller, of Bartow, vice president, and Dr. Charles Larsen Jr., of Lakeland, secretary-treasurer.

St. Johns

Dr. Milton Segal, of St. Augustine, has been elected president of the St. Johns County Medical Society succeeding Dr. Reuben J. Plant Jr. Dr. Reddin Britt has been elected vice president, Dr. William J. Gibson, secretary, and Dr. Vernon A. Lockwood, treasurer. Drs. Britt, Gibson and Lockwood are also from St. Augustine.

St. Lucie-Okeechobee-Martin

Dr. John M. Gunsolus, of Stuart, has begun serving as president of the St. Lucie-Okeechobee-Martin County Medical Society following his election at the recent annual meeting. Serving with Dr. Gunsolus are Dr. Howard C. McDermid, of Fort Pierce, as vice president, and Dr. Adrian M. Sample, also of Fort Pierce, who was reelected secretary-treasurer.

Sarasota

Dr. Samuel E. Kaplan, of Venice, has been installed as president of the Sarasota County Medical Society. Dr. Karl R. Rolls, of Sarasota, has been chosen president-elect. Dr. Rolls was formerly secretary.

Dr. James E. Kicklighter, also of Sarasota, has been elected secretary to replace Dr. Rolls, and Dr. Millard B. White, of Sarasota, has been reelected treasurer.

Seminole

Dr. Gordon D. Stanley has been elected president of the Seminole County Medical Society to succeed Dr. William V. Roberts. Dr. Daniel H. Mathers has been elected vice president, and Dr. Terry Bird has been reelected secretary. All are from Sanford.

Suwannee

Dr. Hiram B. Curry, of Jasper, has been elected president of the Suwannee County Medical Society. He served as secretary last year. Dr. William P. Blackmon, also of Jasper, has been chosen secretary.

Taylor

Dr. Charles R. Wiley has been elected president of the Taylor County Medical Society for the year 1957, and Dr. Ralph J. Greene, secretary. Drs. Wiley and Greene are from Perry.

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Adult dosage for Achrocidin Tablets and new, caffeine-free Achrocidin Syrup is two tablets or teaspoonfuls of syrup three or four times daily. Dosage for children according to weight and age.

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Tablets and Syrup

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Phenacetin	120 mg.
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Volusia

Dr. Arthur Schwartz has been chosen by the members of the Volusia County Medical Society as president for the current year. Elected at the recent annual meeting to serve with Dr. Schwartz was Dr. Hugh Crawford as vice president and Dr. Achille A. Monaco who was reelected secretary-treasurer. All the officers are from Daytona Beach.

Walton-Okaloosa

Dr. Ralph B. Spires, of DeFuniak Springs, has been elected president of the Walton-Okaloosa County Medical Society. Dr. George W. Barrow Jr., of Crestview, formerly secretary-treasurer, has been elected vice president. Dr. Howard A. Parker, of Valparaiso, was chosen to fill the position vacated by Dr. Barrow.

Washington-Holmes

Dr. Walter H. Shehee, of Chipley, has been elected president of the Washington-Holmes County Medical Society. Dr. L. H. Paul, of Bonifay, remains secretary-treasurer.

OBITUARIES

Andrew Monroe O'Hara

Dr. Andrew Monroe O'Hara of Sneads died on Sept. 20, 1956, at Jackson Hospital in Marianna following an illness of several months. He was 67 years of age.

A native Floridian, Dr. O'Hara was born at Live Oak in 1889. He received his elementary education there and his medical training in Georgia. In 1916, he was awarded the degree of Doctor of Medicine by the Georgia College of Eclectic Medicine and Surgery in Atlanta.

For 42 years Dr. O'Hara served Jackson County as a general practitioner. He practiced first at Cypress, remaining there for 15 years before moving to Sneads. He was a member of the Church of Christ at Live Oak and he belonged to the American Legion Post at Sneads and the Masonic Lodge at Grand Ridge.

Dr. O'Hara was a member of the Jackson-Calhoun County Medical Society. He also held membership in the Florida Medical Association.

Surviving are the widow, Mrs. Ida O'Hara; one son, Gene O'Hara, of Sneads; five daughters, Mrs. Rozell Wilson, of East Point, Ga., Mrs. Jacqueline Lanier, of Jacksonville, and Mrs. Nell Corbitt, Mrs. Melba Lanier and Mrs. Bernice

(Continued on page 942)

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A Dependable Antihypertensive

"...by far the most effective

and useful orally administered agent for reducing blood pressure . . . fully worthy of a trial in every case of essential hypertension in which treatment is thought necessary. The severe cases, which always need treatment, are as likely to respond as the mild."[1]

1. Locket, S.: Brit. M.J. *1*:809 (Apr. 2) 1955.

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2. Wright, W.T., Jr., et al.: J. Kansas M. Soc. *57*:410 (July) 1956.

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In moderate to severe hypertension this single-tablet combination permits long-term therapy with dependably stable response. Each tablet contains 1 mg. Rauwiloid (alseroxylon) and 3 mg. Veriloid (alkavervir). Initial dose, 1 tablet t.i.d., p.c.

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In severe, otherwise intractable hypertension this single-tablet combination provides smoother, less erratic response to hexamethonium. Each tablet contains 1 mg. Rauwiloid and 250 mg. hexamethonium chloride dihydrate. Initial dose, ½ tablet q.i.d.

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Good evidence that if you're a coffee lover, you'll enjoy Instant Sanka. Because Instant Sanka is 100% pure coffee—rich and full-bodied. Only caffein has been removed.

And just as a reminder—why not tell your caffein-sensitive patients about Instant Sanka Coffee? They can drink as much Instant Sanka as they want without being bothered by sleeplessness or jitters due to caffein.

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97% caffein-free**

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relieves the discomfort of colds

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with CODEINE PHOSPHATE

shortens the "miserable" period by:

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- Relieving muscular aches and pains

prompt symptomatic relief of colds with ***minimum addiction liability***

Available in four strengths

gr. 1/8	gr. 1/4	gr. 1/2	gr. 1
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% **EFFECTIVE** in respiratory infections luding the 25% due to resistant hylococci.[1-3]

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EFFECTIVE in diverse infections includ- the 21% due to resistant pathogens.[1,5]

% **EFFECTIVE** in tropical infections in- ing those complicated by heavy bacte- contamination or multiple parasitisms.[7]

1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51. 2. Shalowitz, M., and Sarnoff, H. S.: Personal communication. 3. Shubin, M.: Personal communication. 4. La Caille, R. A., and Prigot, A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 67. 5. Winton, S. S., and Cheserow, E.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 55. 6. Cornbleet, T.: Personal communication. 7. Loughlin, E. H.; Mullin, W. G.; Alcinder, L., and Joseph, A. A.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 63.

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Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Acetylsalicylic Acid	gr. 3½

'CODEMPIRAL'® No. 3(N)

Codeine Phosphate	gr. ½
Phenobarbital	gr. ¼
Acetophenetidin	gr. 2½
Acetylsalicylic Acid	gr. 3½

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Tuckahoe, N. Y.

(Continued from page 936)

Dennis, all of Sneads; four brothers, Schley O'Hara, of St. Petersburg, George O'Hara, of Hawthorne, Marvin O'Hara, of Live Oak, and Leonard O'Hara, of Gainesville; and 22 grandchildren.

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The component auxiliaries of the Woman's Auxiliary to the Florida Medical Association are interested in the health problems of their communities and have found ways they can assist in solving these problems.

Because gifts to our medical schools are an aid to health, one of the major projects of the national, state and county auxiliaries is the American Medical Education Foundation. Money given through this fund is free and clear; the school decides how the money shall be spent: on building, salaries, research, student aid, etc. Money given by doctors and their wives may be earmarked for a particular school and that school receives the whole sum, for all overhead of the Foundation is paid for by the American Medical Association. Money not earmarked is prorated to

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all medical schools, each receiving an amount commensurate with its share. To my knowledge, this is the only charity where every cent of the money is passed on and where complete freedom in expenditure is left to the recipient. This is worth thinking over — and if, as we all say, we believe in the voluntary way, be it hospital insurance or support of medical schools, then we have the obligation of proof by contributing.

Because we know we need more nurses, particularly in hospitals, the state and component auxiliaries sponsor Future Nurses Clubs. Made up of high school girls, these clubs are given some orientation into nursing and are encouraged to find out more prior to entering nursing school. This accomplishes two things: It provides the student with an understanding of what will be expected of her and, on the other hand, it keeps out many girls who have a romantic notion of nursing. By the first of these, girls entering nursing school are more prone to finish their three years training and, by the second, they are not taking places in the nursing school that could go to a girl who would be more than willing to stay and graduate. The auxiliaries began this program five years ago and four years ago in Florida we had our first Future Nurses Clubs. The program has grown in this period into one of the largest programs in Florida and is becoming almost too large for the auxiliary to carry without outside help. It has already been responsible for many students entering nursing school and will continue to be responsible for an ever increasing number.

Because we know there are many deserving students desiring to enter nursing or one of the other allied professions who cannot afford the tuition and other costs, the component auxiliaries have set up funds to assist them. The state auxiliary also has a fund known as the Student Loan Fund which is used to match funds of component auxiliaries up to $150.00 per year. Thus far, we have had to confine loans to nurses but in the future, as the fund grows and as we interest more people in assisting, we hope to be able to include the other allied professions and medical students. We know of one instance this year where nursing students were assisted without auxiliary help. If this trend continues, the auxiliary funds could be used for loans to students in the other allied professions. The need for trained personnel in all fields is great and the more we help to solve the problem by voluntary giving, the more we continually affirm the philosophy we believe in.

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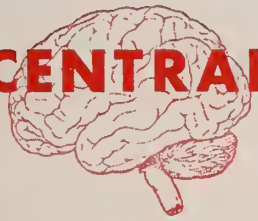

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Dihydrocodeinone bitartrate	1.33 mg.
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Ammonium chloride	70.0 mg.
Menthol	1.0 mg.
Chloroform	0.02 cc.
Alcohol	8%

Bottles of 16 fl. oz.

EXEMPT NARCOTIC

Individually many of our members are giving time to help voluntary agencies. In some instances this aid is no more than stuffing envelopes, in other instances it is testing children at Guidance clinics. It must be remembered that few of us are MD's, however, we have many members trained and experienced in other fields of science who are willing to help where they can be used. There are many of us trained in other professions which readily lend themselves to aiding our medical societies or voluntary health agencies.

It would be impossible to list what each individual or component auxiliary is doing, but the whole picture shows that the auxiliary is touching and aiding the health of Florida people in every section of the state. Needless to say the doctor's wife is the real public relations agent along lines of health and interpretation of the medical association and its work. Because they are not doctors, sometimes the job they do is better than when the doctor speaks for himself.

Let us not forget, however, that each doctor's wife needs to know the philosophy of the medical association and why it takes the stand it does on some issues. This is necessary in order for her to interpret correctly and wisely what the doctor stands for and why.

On the basis of our belief in the voluntary way, we can think of nothing better as proof than volunteering and giving voluntarily. He who stands and objects but does not try to improve; he who gripes and gives nothing, either of himself or from his pocket; he who cannot find the time nor interest in obtaining or giving funds to help the voluntary way, brands himself the spouter of mouthings that have no meaning.

Your auxiliary members are trying to prove that we *do* believe what we say by helping in every way we can and by participating in what we believe will help most in Florida—the things the Florida Medical Association has helped us arrive at as the most important things we can do.

Mrs. Richard F. Stover.

BOOKS RECEIVED

Principles of Clinical Electrocardiography. By Mervin J. Goldman, M.D. Pp. 310. Price, $4.50. Los Altos, Calif., Lange Medical Publications, 1956.

This review of elementary electrocardiography is a unique yet fundamental book on a difficult specialty. It should be of widespread interest to students and practitioners who wish to deepen their understanding of the principles of electrocardiography. Copiously illustrated, the volume sets forth well the teaching abilities of the author and his conceptual grasp of his subject. In presenting here the basic concepts of electrocardiography and

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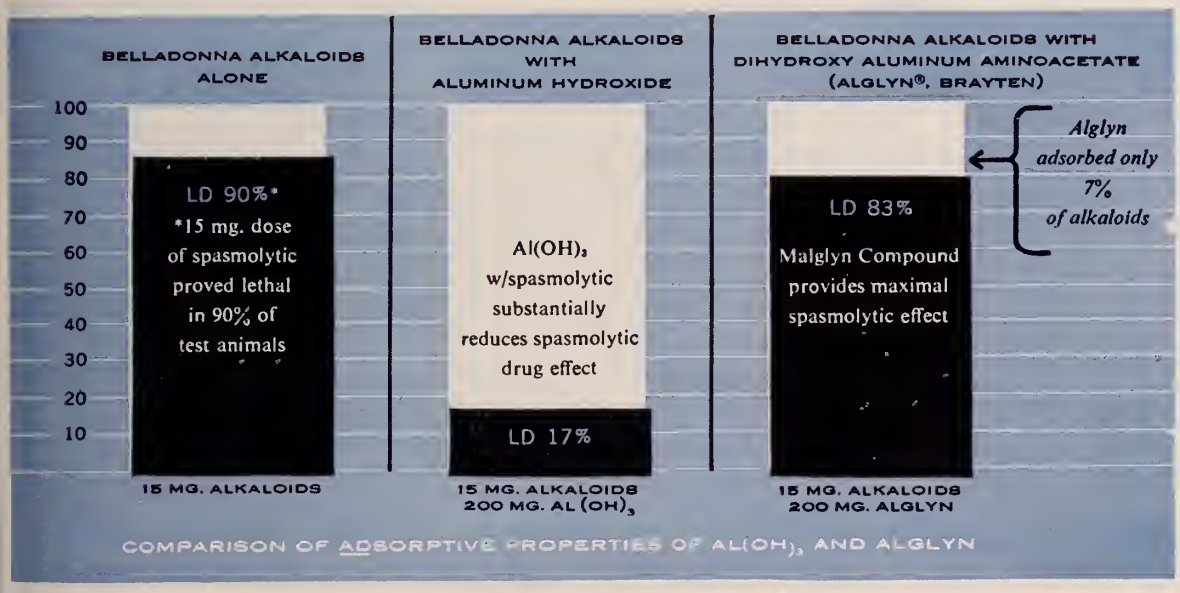

The above laboratory study clearly indicates that the antacid ALGLYN, contained in the MALGLYN formula, does not materially interfere with the therapeutic effectiveness of its contained belladonna alkaloids. On the other hand, the marked *ad*sorptive properties of aluminum hydroxide renders its combination with belladonna alkaloids both uneconomical and therapeutically unreliable.

For both rapid and prolonged antacid effect, with consistently effective spasmolytic and sedative action, rely upon MALGLYN for treatment of peptic ulcer and epigastric distress.

each tablet contains

dihydroxy aluminum aminoacetate, N.N.R.	0.5 GM.
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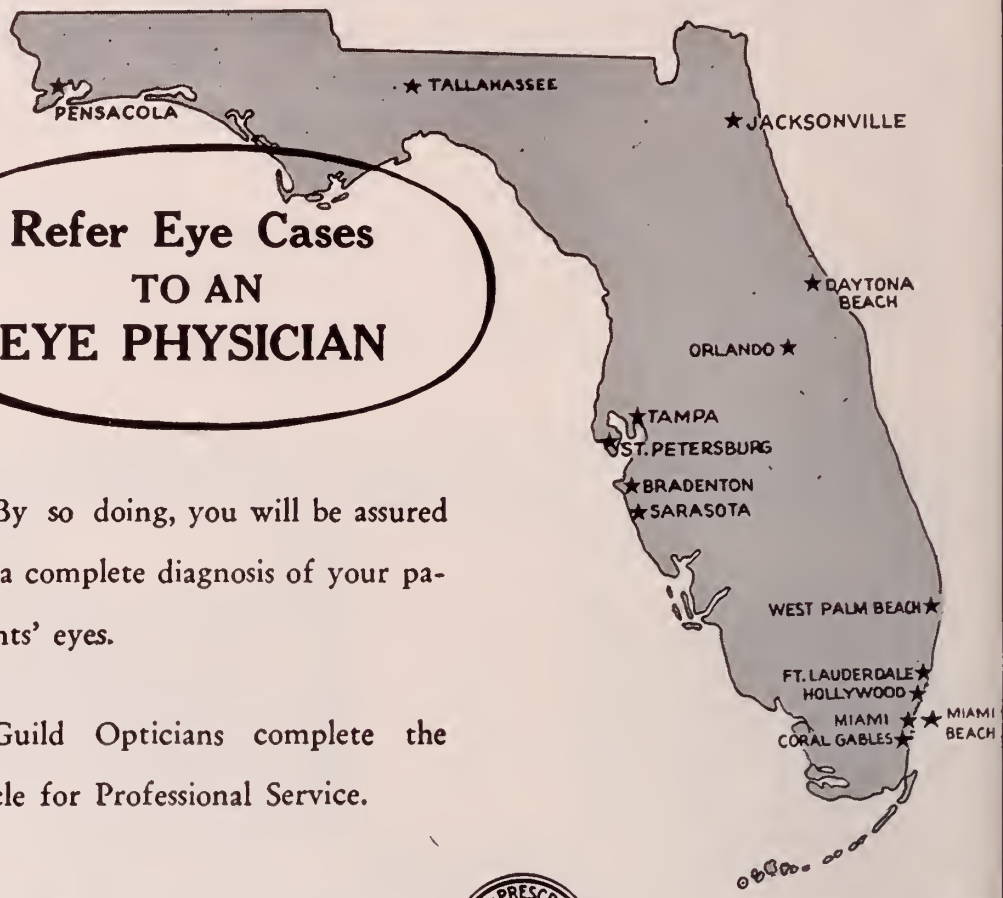

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their clinical application, he has placed emphasis on the unipolar leads as the more logical approach to the subject material. He acknowledges that the unitarian concept of the atrial arrhythmias and the theory of accelerated conduction are not universally accepted, but believes that these are the most acceptable theories of the phenomena under discussion which are available at the present time. He states that he cannot too strongly emphasize the fact that the electrocardiogram is a laboratory test only. Like all laboratory findings, an abnormal electrocardiographic tracing is significant only when interpreted in the light of clinical findings. Ideally, in his opinion, the person best qualified to interpret the electrocardiogram is the physician caring for the patient.

Ciba Foundation Colloquia on Ageing. Volume 2, Ageing in Transient Tissues. Editors for the Ciba Foundation, G. E. W. Wolstenholme, O.B.E, M.A., M.B., B.Ch., and Elaine C. P. Millar, A.H.W.C., A.R.I.C. Pp. 263. Illus. 96. Price, $6.75. Boston, Little, Brown and Company, 1956.

This volume records the second conference on aging sponsored by the Ciba Foundation. The papers and discussions deal with studies on the aging of tissues, the normal life of which is shorter than that of the organism as a whole. The book provides an excellent example of the conferences arranged by the Foundation to promote international cooperation in scientific research and will interest clinicians and research workers alike. A partial table of contents includes organ culture studies of fetal rat reproductive tracts, the age factor in some prenatal endocrine events, the regenerative capacity of ovarian tissue, the history and fate of redundant follicles, mitochondrial changes in different physiologic states, chronologic changes in placental function, modifications in the fetal development of the rat after administration of growth hormone, aging of the axillary apocrine sweat glands in the human female, and aging in human red cells. Twenty-seven authorities, from both sides of the Atlantic, participated in this symposium.

Chronic Illness in the United States. Volume II. Care of the Long-Term Patient. Commission on Chronic Illness. Pp. 606. Price, $8.50. Published for The Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1956.

This book is the first publication in a four volume series on Chronic Illness in the United States. It deals with the care of the long term patient in both home and institution. The term "care" is used in the broad sense to include not only rehabilitation, but the problems of training personnel, coordinating and integrating services, carrying out research, and financing the care of the chronically ill. In presenting this volume, the Commission on Chronic Illness has drawn upon information resulting from its own activities including especially the 1954 National Conference on Care of the Long-Term Patient, which was held under its auspices. It has also drawn freely on additional sources and here synthesizes, from its own experience and from the knowledge of many persons and the work of many communities, the best current information and opinion concerning the care of persons with prolonged illness.

This series should make a major contribution toward better care of the chronically ill. The first volume, dealing with Prevention of Chronic Illness, the third, a study of Chronic Illness in a Rural Area, and the fourth, a similar study of Chronic Illness in a Large City, are yet to be published for The Commonwealth Fund.

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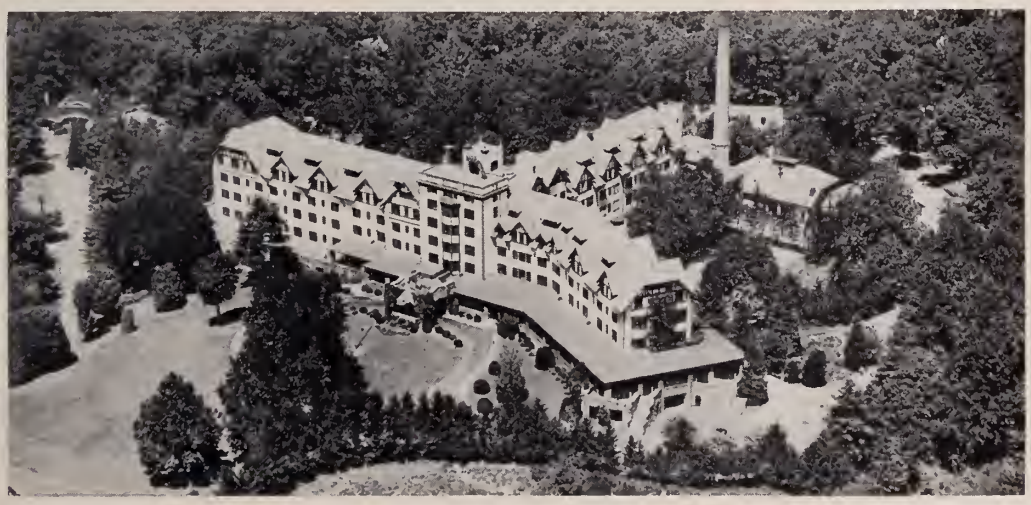

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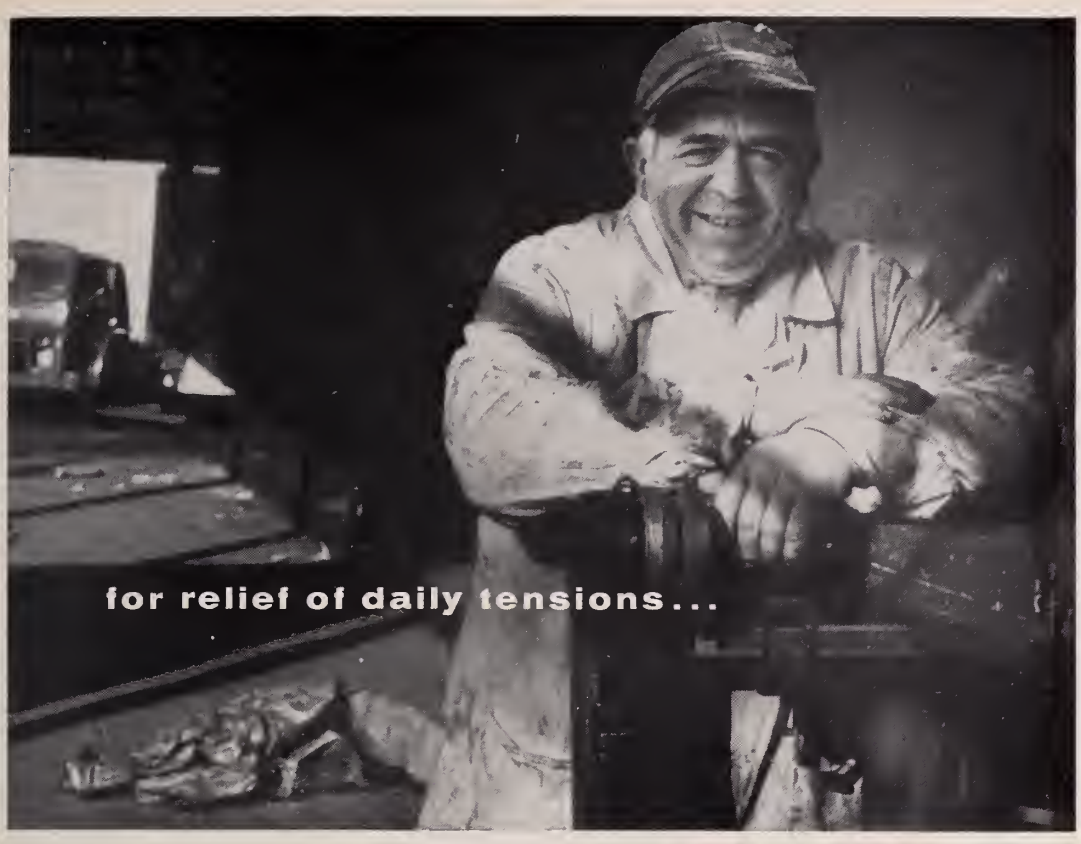
County Medical Societies of Florida

SOCIETY	PRESIDENT	SECRETARY	Meeting Date	Active Members
Alachua	Glenn O. Summerlin, Gainesville	Eugene H. Cummings, Gainesville	2nd Tues.	63
**Bradford, Gilchrist, Union*				
Bay	John J. Benton, Panama City	Lloyd B. Harrison Jr., Panama City	1st Tues.	29
Brevard	Myron L. Habegger, Rockledge	Louis C. Jensen Jr., Cocoa	2nd Tues.	39
Broward	Walter J. Glenn Jr., Fort Lauderdale	Garland M. Johnson, Fort Lauderdale	4th Tues.	141
Collier	James A. Craig, Naples	Ethel H. Trygstad, Naples	3rd Wed.	9
Columbia	Thomas H. Bates, Lake City	Laurie J. Arnold Jr., Lake City	1st Mon.	10
**Baker*				
Dade	Walter W. Sackett Jr., Miami	Vincent P. Corso, Miami	1st Tues.	758
DeSoto-Hardee-Highlands-Glades	Godfrey L. Beaumont, Sebring	Theodore W. Weeks Jr., Sebring	1st Tues.	27
Duval	Leo M. Wachtel Jr., Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	315
**Clay*				
Escambia	Paul F. Baranco, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	106
**Santa Rosa*				
Franklin-Gulf	Photis J. Nichols, Apalachicola	William F. Wager, Port St. Joe	Last Wed.	6
Hillsborough	Madison R. Pope, Plant City	James A. Winslow Jr., Tampa	1st Tues.	213
Indian River	Walter W. McCorkle, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	9
Jackson-Calhoun	William W. Richardson, Graceville	Francis M. Watson, Marianna	Quarterly	16
Lake	Fred A. Vincenti, Mount Dora	J. Basil Hall, Tavares	1st Wed.	30
**Sumter*				
Lee-Charlotte-Hendry	James L. Bradley, Fort Myers	George D. Hopkins II, Fort Myers	3rd Mon.	36
Leon-Gadsden-Liberty-Wakulla-Jefferson	George S. Palmer, Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	67
Madison	Julian M. DuRant, Madison	A. Franklin Harrison, Madison		6
Manatee	Joseph A. Gibson, Bradenton	Warren G. Darty, Palmetto	2nd Tues.	26
Marion	John D. Lindner, Ocala	Robert L. Gibson, Ocala	3rd Tues.	32
**Levy*				
Monroe	Robert W. Reid, Key West	Joseph J. Scarlet, Key West	1st Thurs.	14
Nassau	Benj. F. Dickens, Fernandina Beach	David D. Bennett, Callahan	1st Thurs.	8
Orange	Frank J. Pyle, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	200
**Osceola*				
Palm Beach	Edward W. Wood, Lake Worth	Robert Y. Wheelihan, Riviera Beach	4th Mon.	151
Pasco-Hernando-Citrus	Frank Y. Robson, New Port Richey	W. Wardlaw Jones, Dade City	2nd Thurs.	16
Pinellas	Percy H. Guinand, Clearwater	Whitman C. McConnell, St. Petersburg	1st Mon.	236
Polk	John P. Tomlinson Jr., Lake Wales	Charles Larsen Jr., Lakeland	2nd Wed.	106
Putnam	Alfred P. Peretti, Palatka	Norman B. Egerton, Palatka	2nd Tues.	9
St. Johns	Milton Segal, St. Augustine	William J. Gibson, St. Augustine	3rd Tues.	20
St. Lucie-Okeechobee-Martin	John M. Gunsolus, Stuart	Adrian M. Sample, Fort Pierce	3rd Thurs.	23
Sarasota	Samuel E. Kaplan, Venice	James E. Kicklighter, Sarasota	2nd Tues.	61
Seminole	Gordon D. Stanley, Sanford	Terry Bird, Sanford	2nd Tues.	19
Suwannee	Hiram B. Curry, Jasper	William P. Blackmon, Jasper	1st. Sat.	11
**Hamilton, Lafayette*				
Taylor	Charles R. Wiley, Perry	Ralph J. Greene, Perry	Last Fri.	5
**Dixie*				
Volusia	Arthur Schwartz, Daytona Beach	Achille A. Monaco, Daytona Beach	2nd Tues.	85
**Flagler*				
Walton-Okaloosa	Ralph B. Spires, DeFuniak Springs	Howard A. Parker, Valparaiso	3rd Tues.	21
Washington-Holmes	Walter H. Shehee, Chipley	L. H. Paul, Bonifay		2
			Total	2,925

*Supervise and aid until organized separately.



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*Ferguson, J. T.: J. Am. Geriatrics Soc. *4*:1080, 1956.

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1. Personal communication to S.K.F.

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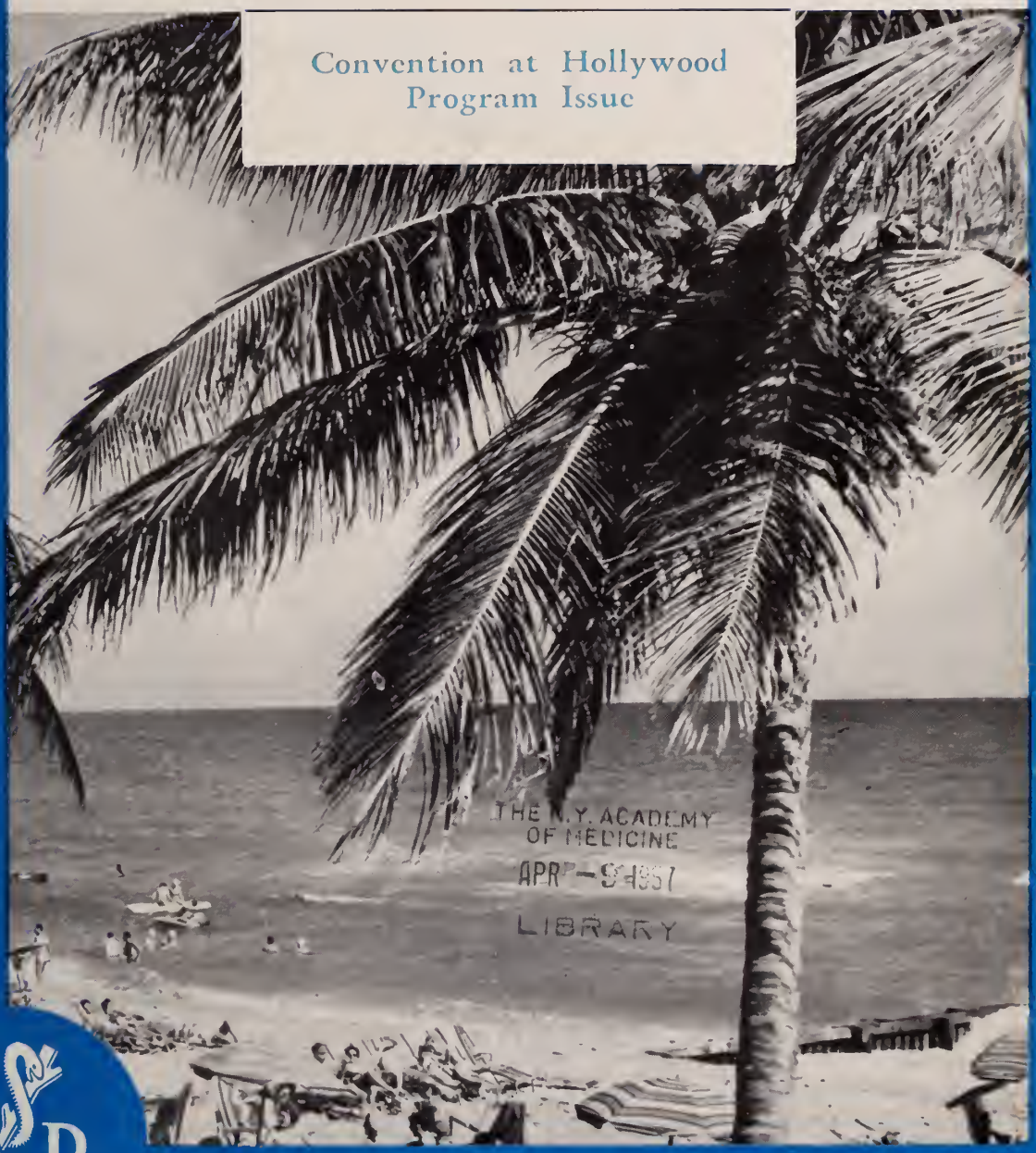
Vol. XLIII APRIL, 1957 No. 10

Convention at Hollywood
Program Issue



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REFERENCES

(1) Finland, M.: *J.A.M.A.* 158:188, 1955. (2) Kirby, W. M. M.; Hudson, D. G., & Noyes, W. D.: *Arch. Int. Med.* 98:1, 1956. (3) Wise, R. I.; Cranny, C., & Spink, W. W.: *Am. J. Med.* 20:176, 1956. (4) Rantz, L. A., & Rantz, H. H.: *Arch. Int. Med.* 97:694, 1956. (5) Kempe, C. H.: *California Med.* 84:242, 1956. (6) Spink, W. W.: *Ann. New York Acad. Sc.* 65:175, 1956. (7) Felix, N. S.: *Pediat. Clin. North America* 3:317, 1956. (8) Altemeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elstun, W., & Fultz, C. T.: *J.A.M.A.* 157:305, 1955. (9) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (10) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (11) Perry, R. E., Jr.: *North Carolina M. J.* 16:567, 1955. (12) Horton, B. F., & Knight, V.: *J. Tennessee M. A.* 48:367, 1955.

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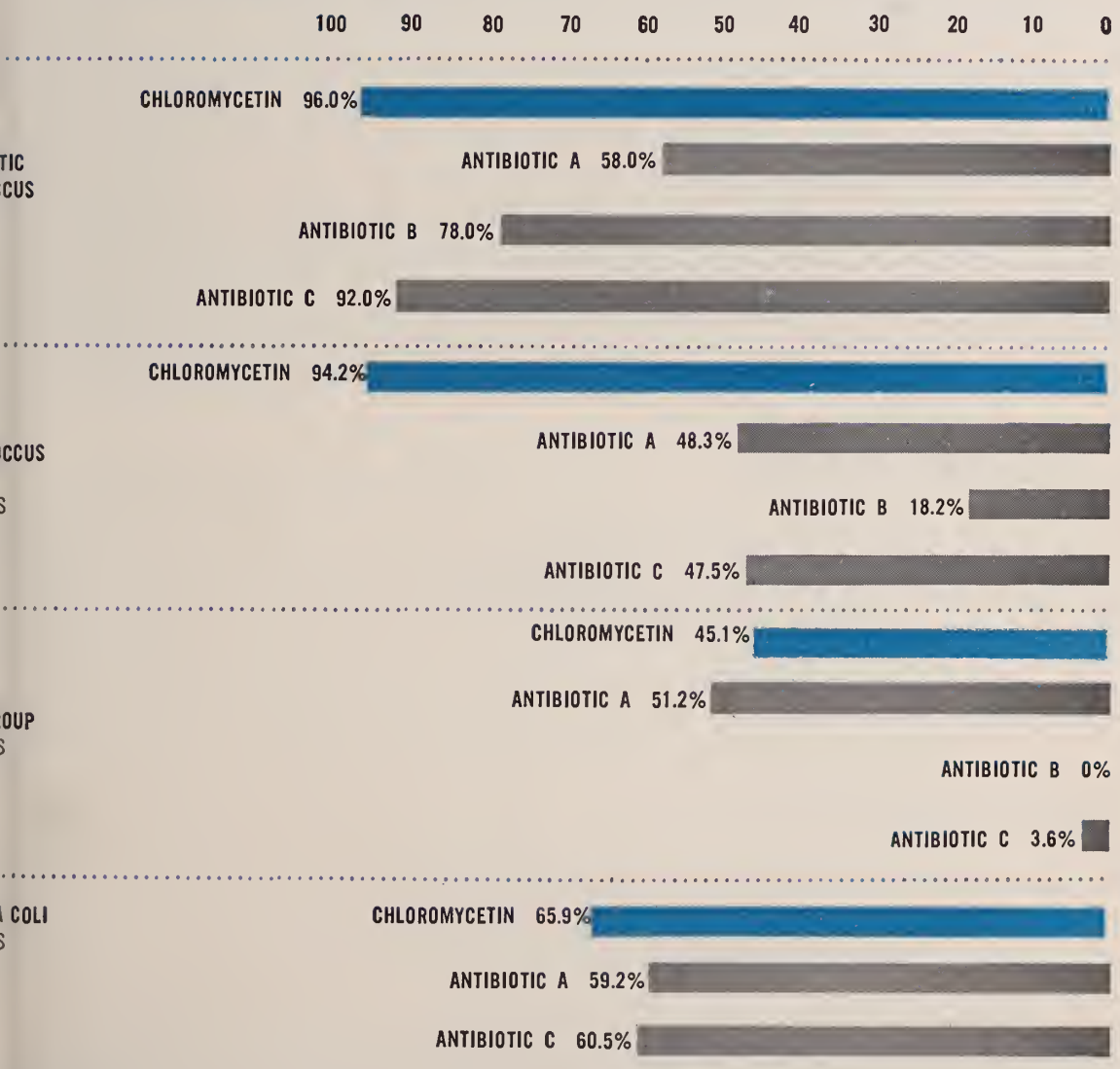

*This graph is adapted from Rantz and Rantz.[4] It is based on *in vitro* studies of bacteria freshly isolated from clinical materials.

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VOLUME XLIII, No. 10 • *April, 1957*

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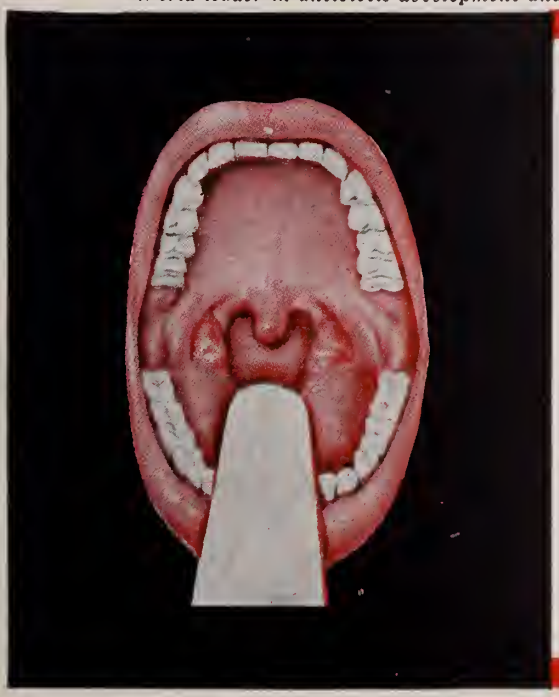

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1. Carter, C. H., and Maley, M. C.: Antibiotics Annual 1956-1957, New York, Medical Encyclopedia, Inc., 1957, p. 51.

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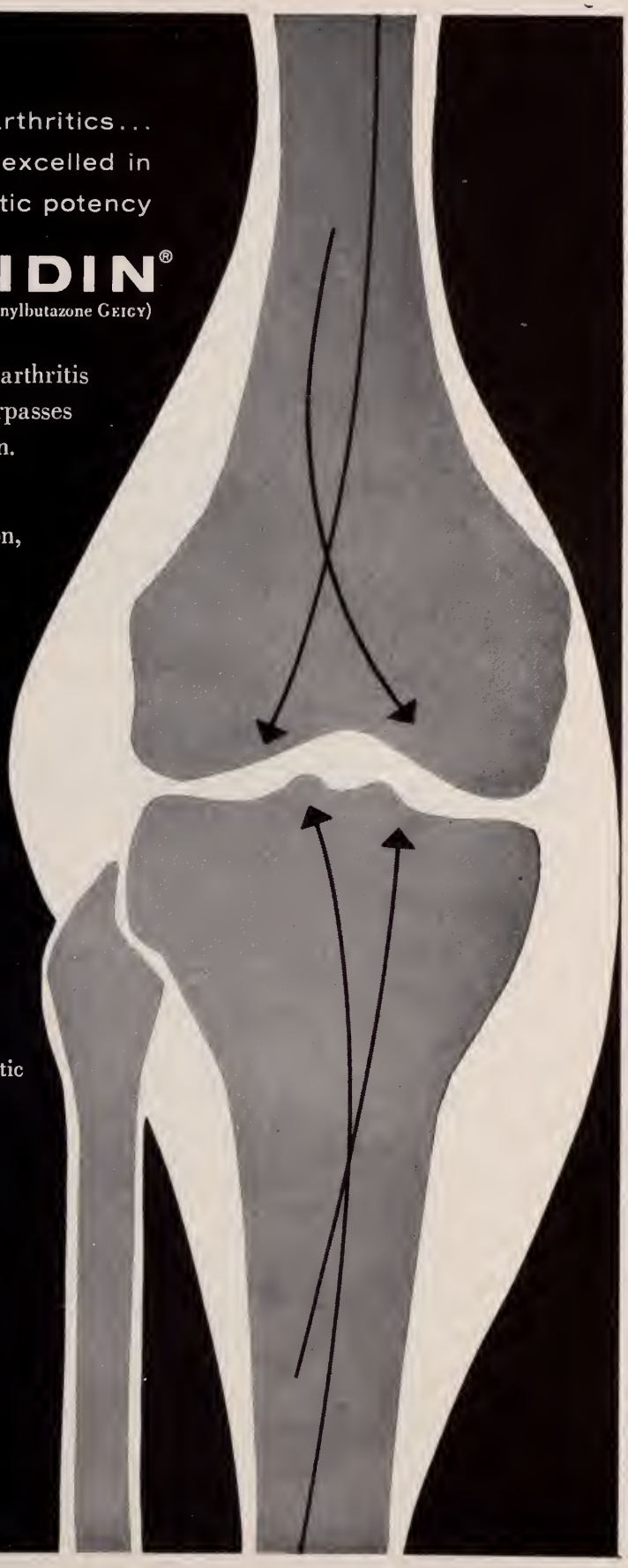

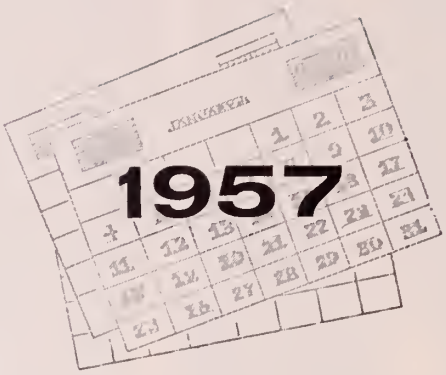

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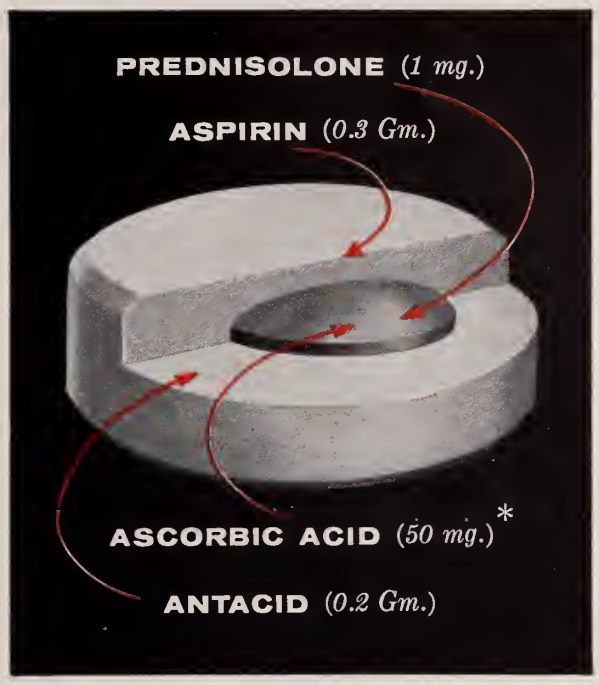

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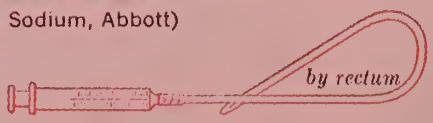

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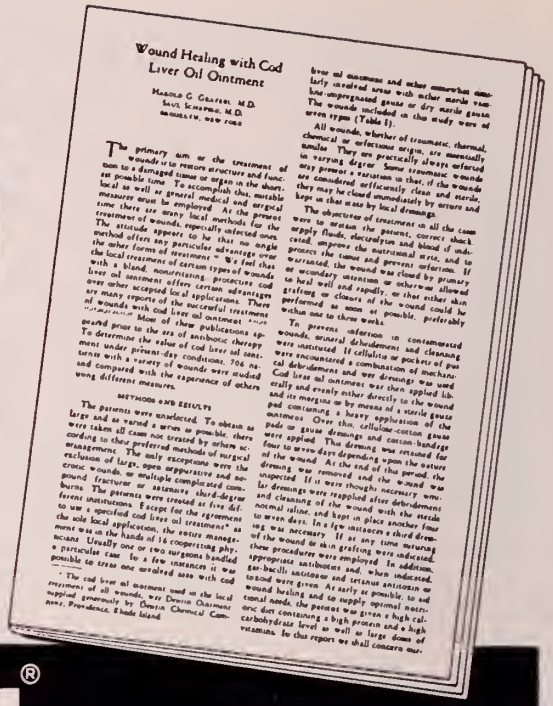
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Management of Acute Craniocerebral Trauma

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In this day of increasing horsepower and the consequent increase in speed and congestion on the highways, automobile accidents are a daily hazard. Approximately 25 per cent of the injuries sustained in automobile accidents are injuries to the head. It is, therefore, important that all physicians be familiar with the care and treatment of patients with head injuries. This publication is a review of the present day accepted management of acute head injury. No effort at original contribution is attempted, but the gravity of the situation renders such a review timely.

The pertinent medical history of a patient with head injuries is of paramount importance, as in all medical diagnosis. A brief statement as to time, place and type of accident is also important from the medicolegal aspect. Because of the patient's condition it may be necessary, in order to obtain reliable information, to question other passengers, eye witnesses, or the police. It is important in properly evaluating the patient, to know what the state of consciousness was immediately after the accident. This becomes especially important if there was unconsciousness followed by a lucid interval and subsequent progressive loss of consciousness. A history or manifestation of excessive drinking prior to the accident should not, in any way, deter the physician from obtaining a complete history and making a thorough physical examination, including a careful neurologic evaluation. It should, in fact, render such an investigation imperative, so that any evidence of damage to the brain may be detected and proper treatment instituted.

Following the history, a thorough and complete physical examination should be made. It should be pointed out that when shock is present, there is usually another associated injury which must be revealed and evaluated. On occasion, with lacerations of the scalp, patients may suffer sufficient hemorrhage to cause shock when first seen. All unconscious patients should be carefully examined for evidence of injury to the cervical spine, thorax, abdomen and extremities.

The initial neurologic examination is of utmost importance, and careful notes should be made as a basis for future evaluation of the patient. The state of consciousness should be accurately recorded and, if a change of consciousness is present, some indication of its degree, that is, how the patient responds to stimuli and what stimuli. It is only a deeply comatosed patient who will not respond to firm supraorbital pressure. The pupils should be checked for size and equality. The neck is checked for the presence of nuchal rigidity. The limbs are checked for alterations in tone.

Following the history and examination, decision must be made as to whether or not the patient needs an immediate surgical procedure. It should be mentioned that with the exception of repair of scalp lacerations, only 10 to 15 per cent of patients with head injuries require surgical intervention of any type.[1]

Sound Physiologic Balance

Care of the unconscious patient calls for strict and constant observation, and every effort should be made to maintain a sound physiologic equilibrium. The important features of this equilibrium are as follows:[2]

1. MAINTENANCE OF AN ADEQUATE AIRWAY AND OXYGENATION. — Maintaining an adequate airway and oxygenation is of extreme importance and should receive primary consideration. Without proper oxygenation, hypoxia results, which not only causes cerebral malnutrition but al-

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so increases cerebral congestion. The patient with a head injury does best if the head of the bed is elevated slightly, 15 to 20 degrees, for when flat, venous drainage of the brain is hampered and congestion is increased. This position is in contrast to that of the usual unconscious patient, who is placed on his side so that the secretion in the upper respiratory tree will drain adequately. A suction apparatus equipped with a soft rubber catheter is placed by the bedside and used frequently and judiciously. Oxygen is usually necessary and is given by nasal catheter. If there is serious obstruction to the free exchange of air or if labored respirations develop, a tracheotomy is performed at once, usually at the bedside. This assures an adequate airway and lessens the danger of aspiration of vomitus.[3]

2. Correction of Shock. — If shock is present, immediate steps must be taken to correct it and maintain proper circulation. The administration of whole blood is the best available agent for combating shock, and there is no contraindication to the use of blood in any patient with head injuries. Other general measures include warmth and oxygen, and are used as needed. A search must be made for the underlying cause of shock and efforts made to correct it.

3. Control of Temperature. — Hyperthermia is a frequent accompaniment of cerebral injury. If the temperature rises above 102 F., measures to combat it should be taken at once. Twenty to 30 grains of acetylsalicylic acid are given rectally. Alcohol sponges are administered, and ice packs may be applied to the body. If these measures fail, a wet sheet may be placed over the patient and an electric fan directed over the patient. Frequent ice water enemas may, occasionally, be necessary.

4. Proper Fluid Balance. — Fluid balance is not of prime consideration for the first few hours. Restriction of fluids, as formerly practiced, is deemed unnecessary, and it is thought that the patient does better if the urinary output is approximately 1,000 cc. daily. In the absence of excessive perspiration or hyperthermia, 2,000 to 3,000 cc. of intravenous fluids usually is adequate for 24 hour periods. Sodium intake is kept at a minimum in the first 24 hours. If coma is prolonged, blood electrolyte studies are obtained daily or every few days, depending on the patient's condition. Most neurosurgical centers have abandoned the use of hypertonic glucose solution for the relief of intracranial pressure, and it has little use in the present day management of head injuries. It is true, however, that the intracranial pressure will be lowered, but in a short time the pressure has returned to its former level and frequently even higher.

5. Maintenance of Nutrition. — If coma persists for more than four or five days, a Levin tube should be inserted and a daily intake of approximately 2,000 calories given in divided doses. The protein content should be adequate to prevent the occurrence of a protein deficiency, which occurs rapidly in comatose patients. The Levin tube may also be used to administer the necessary fluids, often eliminating the necessity for intravenous solutions. When a Levin tube is used for feedings, the danger of vomiting with subsequent aspiration is increased, and diligent observation is required.

6. Care of the Bladder. — Distention of the urinary bladder frequently increases restlessness in a comatose patient, and often such a patient becomes quiet after catheterization. Those patients with head injuries who are not too restless may have an indwelling catheter inserted and connected to the usual reservoir. Other patients are given external catheter drainage rather than chance their injuring themselves by a sudden pull on an indwelling catheter.

7. Control of Restlessness. — Extreme restlessness is often a severe problem in the management of the patient with head injury. Restraints often increase the restlessness as the patient struggles even harder to escape. They are not recommended for the usual comatose person. Four to 6 cc. of paraldehyde may be given by intramuscular injection into each buttock in the extremely restless patient. In less violent patients 2 to 4 grains of phenobarbital sodium intramuscularly at four hour intervals will frequently aid in quieting them. Thorazine is of great value in the control of any restless person. The usual dosage is 50 mg. intramuscularly three or four times a day.

Care of the skin by frequent turning, at least every three hours, and general cleanliness are maintained as in all bedridden patients.

Careful Observation of the Patient

All persons who are rendered unconscious should have a series of skull roentgenograms before discharge from the hospital. It is not necessary, however, that they be taken upon arrival in the emergency room. The presence of a simple linear fracture of the skull is of little importance

per se. It is the associated damage to the brain which is of primary concern. A critically ill patient should not be subjected to the further disturbance of being moved several times to secure roentgenograms unless there is some specific reason, such as a compound fracture that requires immediate debridement or a suspected epidural hematoma. In these injuries the site of a fracture is often of considerable aid in surgical exploration.

In the past, there has been much debate about the relative merits of lumbar puncture in the management of acute craniocerebral trauma. It is seldom of much value and on occasion may be dangerous. The presence of blood is of some medicolegal importance, and the relative amount may have some prognostic value. Arguments that the blood should be removed by lumbar puncture have been disproved, and it is now accepted that significant amounts of blood cannot be removed in this manner.[4] It is also true that lumbar puncture occasionally will reduce increased intracranial pressure, but the time period is relatively short. Most authorities now believe that its chief value is in the occasional relief of headaches and subsequent restlessness following trauma.

All patients who are rendered unconscious should be admitted to the hospital for continued observation for a period of at least 24 hours. If hospitalization is unavailable, a relative or other reliable person should be instructed how to observe the patient at hourly intervals for the first 24 hours and informed of the signs for which to look. Should stupor, weakness, or pupillary inequality occur, the responsible physician should be called at once.

In the care of hospitalized patients, superior nursing personnel is of the utmost importance; however, the presence of specially trained personnel does not, in any way, lessen the responsibility of the attending physician. Instructions should be written so that, among other things, the patient will have his blood pressure, pulse and respiration checked every 30 minutes for the first 12 hours as well as any changes in the state of consciousness. If there is any significant change in any of these, the responsible physician is called immediately. Should any indication of intracranial bleeding occur, trephination is performed early. It is only by careful observation of patients with head injuries and early trephination that the mortality can be lowered.

Types of Head Injuries

Head injuries may be divided into open and closed injuries. The former refers to those injuries in which there is a direct communication of the brain or its meninges through the bone with the extracranial tissues or environment. The latter refers to those in which there is no communication between the outside tissues or space and the brain and its covering.

The most common head injury is the cerebral concussion. Concussion is a term which is not clearly understood by physicians, attorneys, insurance adjusters and the laity and consequently has been used loosely. Almost everyone who sustains a blow to the head is frequently and erroneously said to have had a concussion. The term concussion should be reserved for use in describing the injury of those persons who, after trauma to the head, suffer from a transitory loss of consciousness due to injury to the brain which is not apparent to the unaided eye, that is, no hemorrhage, laceration or contusion. The period of unconsciousness in the majority of these patients is less than 10 minutes, and they often recover with no immediate residual complaints or complications.[5] If a person is unconscious for a longer period of time, he is almost certain to have more extensive damage and usually contusion and laceration superimposed on the initial concussion.

Contusion literally means a bruise, and cerebral contusion, means a bruise of the brain. In contusion there are numerous scattered petechial hemorrhages which often coalesce and are produced by damage to the blood vessels, usually the veins. The duration of unconsciousness is generally longer than in concussion and may be prolonged, depending on the extent of the lesion.

The third type of closed head injury consists of a combination of contusion and laceration. Herein, there is a laceration of the brain substance in addition to the contused area. This, obviously, is the most severe type of injury; the prognosis for recovery is poor, and the likelihood of permanent sequelae greater. Blood in the cerebrospinal fluid is necessary for diagnosis.

Indications for Surgical Intervention

The indications for surgery in patients who have sustained craniocerebral trauma are:[6]

1. The presence of deepening coma
2. Progressive neurologic changes

3. Evidence of increasing acute intracranial pressure as manifested by bradycardia, increased blood pressure and/or increasing stupor

4. The presence of subacute or chronic increased intracranial pressure as manifested by papilledema

5. Compound fractures of the skull and penetrating wounds of the brain

Contraindications to intracranial surgery are:

1. The presence of surgical shock

2. Minor depressed fractures of the skull

3. The presence of dilated, fixed pupils, a thready pulse and irregular respiration when the patient is admitted to the hospital.

Patients in the third category are not candidates for any surgical procedure, and almost all of such cases terminate fatally.

Special Situations

Special situations requiring attention are:

1. SCALP LACERATIONS. — The scalp is a relatively inelastic tissue covering the skull, which, in addition to serving as a cushion when intact, prevents the entrance of infective agents to the skull and brain. All lacerations should be treated with meticulous care and sound surgical principles. The hair should be shaved well away from the edge to a distance of approximately 2 inches. The shaving should be done from the edge of the laceration outward and every effort made to avoid further contamination of the wound. The wound should be palpated with a gloved index finger before closure. Negative evidence on roentgen examination of the skull is not a substitute for this procedure. The wound is then thoroughly irrigated with sterile saline solution, all contused tissue is surgically debrided, and the wound is closed with interrupted, nonabsorbable sutures. The galea as well as the skin should be closed. Older wounds or contaminated wounds should be closed with mattress sutures which transfix both the skin and the galea. In large lacerations with avulsion of the scalp, relaxing incisions may be necessary, or skin grafting may be required on occasion. With meticulous care of scalp lacerations and the use of sound surgical principles and antibiotics, osteomyelitis and other complications are becoming surgical curiosities.

2. SKULL FRACTURE. — As has previously been stated, simple linear fractures of the vault of the skull are of little importance. It is, however, the associated damage to the brain which is of primary concern. Depressed fractures should be elevated if they are depressed 1 cm. or more. There are several reasons for elevating these fractures, the principal one being to eliminate a possible epileptogenic focus. Frequently, spicules of bone from the inner table will be driven into the dura and are not visible on roentgen examinations. Elevations of these fractures serve to reveal these dural defects, which are then repaired. With simple depressed fractures the larger fragments may be elevated and left in place, thus avoiding large unsightly defects.

3. COMPOUND FRACTURES. — Compound fractures should be thoroughly debrided in the operating room under aseptic conditions. The edges of the scalp are surgically debrided, and all contused tissue is removed after copious irrigation with sterile saline. The depressed fragments of bone are then removed and usually discarded. A thorough search is made for any fragments of bone or foreign material that might be buried within the substance of the brain which at a later date might serve as a nidus of infection. All contused brain tissue is gently removed by suction, and bleeding is controlled by electrocoagulation or silver clips. Any rent in the dura should be closed with interrupted silk sutures and, if necessary, a fascial or pericranial graft applied over the area. The scalp is then closed in layers with interrupted silk sutures. If the resulting defect is unsightly, one of the various cranioplasties may be performed in a few months.

All persons who, following head trauma, bleed from the ears should be considered as having compound fractures of the skull. They should be hospitalized and treated with antibiotics for a minimum of five days before discharge. Following withdrawal of the drugs, these patients should be observed closely for the signs and symptoms of any infectious process.

4. PENETRATING WOUNDS. — Penetrating wounds are treated as are other compound fractures by removing all fragments of bone and devitalized tissue and securing meticulous hemostasis. In the case of bullet wounds, it is not necessary to remove the bullet as it is sterile; however, all fragments of bone, hair and foreign body should be removed if they are surgically accessible.

5. EXTRADURAL HEMATOMAS. — The extradural or epidural hematoma is one of the most treacherous conditions that occur following head trauma. In its classical form, as has been de-

scribed so often, there is a brief period of unconsciousness followed by a lucid interval in which the patient may complain of headaches. This, in turn, is followed by stupor with progression into deep coma. When these conditions are met, it is relatively easy to suspect or diagnose. Especially is this true when there is an associated dilated pupil on the side of the trauma and a weakness and Babinski's response on the contralateral side. The extradural hematoma is frequently encountered, however, without a history of a lucid interval and without pupillary inequality. Fortunately, though, patients with this lesion often show some sign of lateralization, such as reflex inequality, Babinski response or weakness of the extremities. These are usually contralateral to the side of the lesion. In other instances, the mass of blood pushes the brain away in such fashion that there is an impingement of the long motor tracts against the tentorium at the incisura producing ipsilateral reflex changes. It is for this reason that trephination should be carried out bilaterally in all cases of suspected lesions.

Extradural hematomas are usually produced by bleeding from the middle meningeal artery or one of its branches. There is almost always a fracture line crossing the artery or one of its branches. At the time of fracture, the artery is torn and bleeds into the epidural space. In Browder and Cook's series,[7] the fracture was demonstrated in 117 out of 130 such cases. It must be remembered, however, that a fracture is not always demonstrable on roentgen examination, and the absence of a fracture should not influence one in postponing trephination in suspected cases. With the continued bleeding of the artery, the hematoma rapidly enlarges in size. Thus the signs, symptoms and a fatal outcome may occur within the relatively short period of from two to five hours. Fractures over the major venous sinuses may also produce extradural hematoma. In this latter group the signs and symptoms are much slower to appear as the bleeding is much less brisk. Hence, all patients with fractures over a major venous sinus or meningeal artery should be observed most carefully for the first 24 hours.

6. Extradural Hematomas of the Posterior Cranial Fossa. — Extradural hematomas occur much less frequently in the posterior cranial fossa than above the tentorium. Patients with such hematomas do not show the signs of cerebral compression which have been mentioned, but become flaccid, hypotonic and eventually stuporous. They also have a peculiar shallow and jerky respiration. Usually there is a history of a blow to the occipitoparietal region with a linear fracture of the skull seen on roentgen examination. In such patients, burr openings should immediately be made over the cerebellar hemispheres and any clot evacuated.

7. Subdural Hematomas. — Subdural hematomas have been divided into acute, subacute and chronic. Most of the acute ones are caused by a tear in the veins bridging the cerebral cortex to the greater longitudinal sinus or are due to bleeding of one of the cerebral vessels torn during laceration of the brain. The mortality in acute hematoma is inversely proportioned to the time interval between the injury and surgery. The mortality within the first 24 hours is roughly 90 per cent. It is, therefore, better to try to nurse patients with this injury for a few days before attacking the lesions if their general condition permits.

Subdural hematomas usually show signs of lateralization. This occurs, however, at a longer interval after the accident than in extradural hematomas. The usual acute subdural hematoma manifests itself at about 12 hours following injury. There may also be a dilated pupil on the side of the lesion, and there is usually other evidence of localization. Such acute subdural hematomas are difficult surgical problems in that finding and controlling the bleeding point is often a major problem. If, after evacuation of the hematoma, the bleeding point is not found and controlled during the stage of active bleeding, the hematoma usually reforms. Large areas of the skull must be removed or multiple openings made in order to localize the bleeding points. Even this measure is sometimes unsuccessful when the torn vessel is buried in brain tissue.

Subacute subdural hematomas are those that occur approximately three to 10 days following the acute head injury. Patients with these lesions have a much greater chance for successful surgical intervention than do those with acute subdural hematomas. In the presence of any of the signs mentioned under operative indications, these patients should undergo trephination in an effort to relieve the expanding intracranial lesion. These hematomas frequently contain a mixture of blood and spinal fluid,

and some may be removed through simple burr holes. Occasionally, however, there is a clot which requires extensive craniectomy, or preferably a small osteoplastic craniotomy for removal of the lesion.

Chronic subdural hematomas are found weeks to months following the original head trauma and hemorrhage. The initial trauma is often thought to be trivial at the time of its occurrence. This type is a progressively expanding intracranial lesion which produces headaches of varying intensity as well as other symptoms such as convulsions or other types of seizures, personality changes, inefficiency and motor weakness. Obviously, such symptoms are often confused with psychoneurosis. Some of the patients will show some evidence of neurologic impairment, occasionally even papilledema. Frequently there will be no definite evidence of a neurologic lesion. Spinal puncture may reveal xanthochromic fluid which may be under increased pressure. If the lesion is not evacuated, usually there is a continued progression until stupor is followed by coma and death. Roentgen examination of the skull may show a calcified pineal gland that has shifted, which thus gives an indication concerning the location of the lesion. Approximately 20 per cent of chronic subdural hematomas, however, are bilateral, and hence, a displaced pineal gland is not often a reliable sign. Most chronic subdural hematomas can be evacuated by trephine openings. The hematoma membrane is incised and then thoroughly irrigated with warm saline solution through a soft rubber catheter. Occasionally it will be necessary to fashion a small osteoplastic flap. The patients do well if the lesion is attacked before deep coma has occurred and provided the brain re-expands following removal of the clot.

8. SUBDURAL HYGROMA. — A relatively uncommon lesion which occurs following head trauma is the subdural hygroma. It is usually seen several days to several weeks following trauma. It is produced by a small tear in the arachnoid which permits the escape of cerebrospinal fluid into the subarachnoid space, but the opening in the arachnoid is so small that there is no free circulation of fluid. The continued accumulation of fluid produces a space-occupying lesion which causes headaches and usually lateralizing signs. Trephination over the site of the lesion with opening of the dura usually results in a spurt of xanthochromic fluid with a high protein content. After evacuation of the hygroma, it does not usually recur. When evacuating a hygroma, one should make sure there is an adequate opening in the arachnoid in order to allow free circulation of the fluid so that the hygroma will not reform.

9. INTRACEREBRAL HEMATOMA. — A hemorrhage into the substance of the brain may occur following head truma. It usually manifests itself days to weeks following trauma of moderate to severe degree. Most patients will show increasing stupor, have high spinal fluid pressure and may have papilledema. They usually have lateralizing signs such as weakness, hyperactive reflexes on the side contralateral to the hematoma and/or a Babinski sign. Angiography and/or air studies frequently are necessary to localize this lesion adequately. Following localization, an osteoplastic flap is turned, a cortical incision is made to the hematoma, and its contents are evacuated. The mortality in such lesions is rather high.

Summary

A brief discussion of the current management of patients with acute head injuries, including the special situations that occur, has been presented. The principles employed to maintain the unconscious patient in as nearly normal physiologic balance as possible are discussed. The importance of careful and detailed observation of the patient is emphasized. The indications for surgical intervention in acute craniocerebral trauma are given. Should any of the signs of intracranial bleeding develop, early trephination is urged. Exploratory burr holes are not hazardous to the patient and may be life-saving by preventing increased cerebral damage beyond that resulting from the primary injury.

The importance of this review is emphasized since most of the patients with acute craniocerebral trauma are excellently managed by physicians other than the neurosurgeon.

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Discussion

Dr. Benjamin H. Sullivan, St. Petersburg: I have had an opportunity to study Dr. Ehlert's paper in detail. I can endorse what he has said and add that it may be accepted as an accurate guide for the emergency treatment of craniocerebral trauma as practiced by most experienced neurosurgeons. There are a few features which will bear emphasis. Dr. Ehlert has mentioned them, but I believe that they need covering a little more thoroughly.

This lantern slide is of a young lady who had both maxillas torn from her skull, extensive edema of the face, numerous lacerations of the chest and extremities, and a considerable loss of blood. She was dazed, but she was not in true shock. By that I mean there was no lowering of the blood pressure and no great increase in the pulse rate. We deduced that she had only a mild brain injury, probably best classified as cerebral contusion. Because of the possibility that brain surgery for removal of an intracranial blood clot might be necessary, all treatment of the maxillofacial wounds was postponed. When I saw the patient three days after injury, she had recovered from all of the neurologic symptoms. The second slide is another view of the young lady three days after the injury showing the distressing effects of maxillary fractures.

The oral surgeon did what is now considered the proper thing. He waited until the patient was in first class condition before considering any treatment. By that time reduction of the maxillary fractures would have been too formidable a procedure, since the fragments were fixed in bad position.

Six months later the patient is unhappy. She has recovered from all of her wounds, but the malocclusion of her teeth makes it necessary to grind them down considerably. Because of periodontoclasia she may lose some of the teeth. The moral here is that when a patient is under observation for complications of an intracranial lesion, by which we mean blood clots, there is no reason for postponing all other treatment. We know, of course, that we should not treat a patient in extremis except to perform necessary life-saving measures, but after this initial phase has been successfully navigated, many procedures such as setting fractures, institution of traction, and even reduction and immobilization of fractures of the jaw can be safely performed. The surgeon handling the case must push the dentist or orthopedist to perform these procedures.

Lastly, I would like to emphasize and correct a widespread misconception of the gravity of exploratory surgery for intracranial blood clots. This slide shows a burr hole craniotomy in progress. This particular slide is a two-hole craniotomy. It is performed through one or several 1-inch long incisions made under local anesthesia. This procedure is sometimes facetiously called "woodpecker surgery." We bore a hole and take a look. When we perform this so-called multiple burr hole craniotomy, the object is to place the holes as far apart as possible so that the probability of missing a blood clot is lessened. This operation is considerably less traumatic than abdominal exploration. The entire procedure is really painless under local anesthesia. The trauma of surgery is considerably less than the transporting of a wounded patient to an x-ray department, moving him to an x-ray table, and taking several films in various projections. As I gain experience with head injuries, I perform fewer of these exploratory operations, but I still do not hesitate if I have any doubts. Any good surgeon can perform this life-saving procedure, if he will trouble himself to look up the technic.

Dr. Vernon T. Grizzard, Jacksonville: I enjoyed Dr. Ehlert's concise and adequate coverage of this subject. I want to emphasize a few points which he discussed by describing briefly two clinical cases with which I have recently had contact. In the first case, the patient was a man in his forties who fell about 6 feet from a step ladder in a grocery store and struck his head on the floor. He was unconscious immediately, but had begun to awaken before the ambulance arrived. When he arrived at the hospital and was examined in the emergency room, he was perfectly conscious and had no complaints except for mild headache. He did not want to stay in the hospital, but he was persuaded by his attending physician to remain in the hospital overnight. His condition was entirely satisfactory; as I said, he had no complaints except for mild headache, and his neurologic examination, his vital signs and his pupils were perfectly normal in all respects. He was not sent for x-ray examination in spite of his satisfactory condition.

Late in the afternoon he again had mild headache which became increasingly severe during the evening and between 10 and 11 p.m., about eight hours after his injury, he had extremely severe headache and was very drowsy. No particular attention was paid to these symptoms because it was bedtime and he had been knocked out and was expected to have some headache. During the night it was duly charted on the nurse's notes that the patient was sleeping soundly, and then the 6:30 a.m. note on the chart read, "Patient cannot be awakened; apparently unconscious; right pupil dilated and fixed." No one was notified; the nurses' supervisor was not notified, the attending physician was not notified, and the house officer was not called.

The patient's attending physician became aware of the situation when he made routine rounds at 8:15 a.m. He asked us to see the patient when we made rounds at 8:30. At that time the patient was in deep coma. There was no response to any stimulus of any kind. His pulse rate was in the fifties. The systolic blood pressure was elevated. He had a completely dilated fixed pupil on the right side. There were increased reflexes on the left side. The Babinski sign was present on both sides. It was obvious he was suffering from acute intracranial hematoma on the right side, and immediate preparations were made for surgery. He was given 50 per cent glucose intravenously in an attempt to reduce the intracranial pressure temporarily to tide him over until he could reach surgery. Surgery was begun as soon as possible, and a huge extradural hematoma was found on the right side beneath a fracture in the right temporal bone. The hematoma was evacuated, but the patient continued to go down hill and expired about three hours later, some 24 hours after the injury, which was apparently only a minor injury in the beginning.

This case was a tragedy of errors from start to finish. The first mistake, which was only minor, was failure to send the patient for x-ray examination during the afternoon of the day of his admission to the hospital. If the fracture in the right temporal region had been found, he would have been watched more closely. In the second place, orders were not left for routine hourly or more often observation of his consciousness, his vital signs and his pupils. Thirdly, when he became extremely drowsy and complained of terrific headache, it seems these facts were ignored by the nursing personnel and also by the house officer who made his evening rounds. In the fourth place, at 6:30 a.m. when the patient was found unconcious with a dilated fixed pupil, the situation was again ignored. The result is that he lost his life when probably it might have been saved.

Fortunately, the second case ended satisfactorily. The patient was an 18 year old boy who was rendered unconscious immediately when his car overturned. When he reached the emergency room of the hospital, he was responding to some stimuli, but was not aware of his surroundings. The blood pressure was 50/0. He had no neurologic abnormalities except that it was noted by the examining house officer that the right pupil was moderately dilated and was fixed. No further examination of the patient was made. He was sent at once for x-ray examination. The attending neurosurgeon then was called and was told that the patient had a moderately dilated fixed pupil on the right, that he was in shock and that he had been sent to the x-ray department.

When I arrived and examined the patient, a careful examination of the right eye revealed that there was considerable sclerosis in the cornea of that eye. The family had arrived at the hospital, and questioning of the

family revealed that the patient had suffered an eye injury approximately 10 years before and that the eye had been in the same condition for many years. There was moderate abdominal rigidity, which had not been discovered by the house officer. The patient had been given no intravenous fluids, plasma or blood for treatment of shock. Instead, he had been sent for x-ray examination. During the next 24 hours careful observation of the vital signs, the state of consciousness, the pupils and the abdominal situation revealed two things: his consciousness improved rapidly, and under treatment of the shock, the blood pressure rose to normal range and remained there. The abdominal rigidity, however, became worse and worse. There developed a rigid, hard, boardlike abdomen which was extremely tender, and there was considerable vomiting. Observation by a general surgeon over the next two or three days with appropriate laboratory tests revealed that this patient was suffering from an acute traumatic pancreatitis. The shock was due to the abdominal injury and not to the head injury.

So three mistakes were made in the handling of this case. First, a false conclusion was reached because of the superficial examination of the right eye. Secondly, a patient in shock was sent for x-ray examination. He should never have been moved from the emergency room until he was out of shock. Thirdly, the state of shock was attributed to the head injury, and no search whatsoever was made for associated injuries. It could well have been that he might have had a ruptured viscus such as a ruptured spleen and could have gotten into extremely serious difficulty through lack of observation and failure to discover the abdominal signs early. I should like to say again that I greatly enjoyed Dr. Ehlert's paper.

A New Era of Therapy in Psychiatry

LAUREN H. SMITH, M.D.
PHILADELPHIA

It is especially gratifying to be invited to Florida because of the progressive thinking and planning for psychiatry now active in this state. The advances we see throughout the United States, in most places, are due almost entirely to scientific advances — in professional training and stature and in the skill of medicine — but not due to any significant extent whatever to state or similar support. The medical profession of Florida, and also the general public, therefore, are to be warmly commended for this shared responsibility for broad improvements in a realistic manner.

The field of medicine has never lacked drama, and the past two decades share bright limelight of progress in therapy. New procedures and medications have met effectively many problems in tuberculosis; in pediatrics the antibiotics have done much in eliminating dread of infection in early childhood. In fact, these advances not only have influenced the operation of hospitals for tuberculous or pediatric patients, but also have reduced the number of inpatient beds. Similarly, homes or colonies for epileptic patients are now in reduced demand. There are moves at present to change the legal restrictions placed on epileptics in regard to driving or other hazardous activities, because of the fact that doctors in their outpatient medical treatment successfully aid these patients.

Physician-in-Chief and Administrator, The Institute, Pennsylvania Hospital, Philadelphia.

Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami Beach, May 14, 1956.

Psychiatry's New Day Dawns

These dramatic realities experienced recently have been shared but little by psychiatric medicine. At long last, however, it would appear that a new day approaches.

Looking back to the decade following World War I, we find that in psychiatric hospitals limited therapy was conducted mainly through the earnest personal endeavors of dedicated doctors, nurses and attendants, the full time staff members. There were few psychiatrists in private practice. About this time there were approximately 1,200 members in the American Psychiatric Association. In 1956 perhaps the membership is somewhere in the neighborhood of 9,000. Between the 1920s and 1956, however, there was not even a doubling of the number of physicians and staff members in the state hospitals wherein so many psychiatric problems reside. What may be a large numerical increase of trained and interested persons in psychiatric medicine is confined largely to the teaching and research centers, and to the private practice of psychiatry.

Therapy in psychiatry during these decades has moved from a position of ambiguity to one of channeled activity. Psychotherapy has become increasingly specific, and psychoanalysis, even though charged with inexactness, has assumed a definite entity as therapy, not to mention its important widespread impact upon all abstract science and culture.

It is significant to note that during the latter portion of this era, replete with developments in functional or abstract therapy, there has been

intensification of study and progress in those therapies primarily directed at the soma itself. Perhaps it is especially healthy, at a time when the interest has been so significantly centered on the unconscious and its effect on behavior, that a balancing influence through scientific advances of empiric physical treatment should emerge with new interest and strength.

This situation creates a sort of dichotomy, and a well regulated scientific medical approach should correlate the multiple views found in each of these areas. Both functional and organic factors are correlated in physiology, and it is equally important to have correlation in therapeutic activities. Answers to much of this problem must be based, of course, on thousands of research projects, case studies and years of follow-up.

The rise of interest in psychiatry, not only apparent within the fields of medical education, research and practice, but additionally manifested by the general public, has set the stage for the dramatic period in psychiatry. The year 1955 might be termed the "year of decision" in psychiatry. It seems that within that year there was a universal realization that mental health and mental illness are the number one concern of all.

Present Status of Psychiatric Medicine

What do we see about us today indicating the status of psychiatric medicine and its significance to the American public, in other words "the consumer?"

At least every week, if not nearly every day, the New York Times prints a sizable column of news concerning what is happening in treatment or about other items concerned with the care and handling of the mentally ill.

Two weeks ago, at the annual meeting of the American Psychiatric Association, with 3,000 physician-psychiatrists in attendance, it was noted not only that the attendance of the press representatives had increased nearly 30 per cent over previous years, but also that senior seasoned responsible staff men, top live column writers, carried the assignment, not the junior newcomers or sensationalists.

LIFE magazine now proposes to issue soon a feature article on "Research in Schizophrenia." Can it be that the general run of public mind and reading can possibly comprehend the pertinence and significance of "Research in Schizophrenia?" This thought is a little startling. It is my impression, however, that LIFE magazine does not issue articles out of keeping with the interest of the public; it produces a periodical to sell the "most" — to use the vernacular.

What all this means may be justifiably debatable, but one conclusion is inescapable. Mr. John Q. Public is more critically inspecting and critically weighing what he is receiving or should receive in psychiatric medicine.

Critique of Psychiatric Therapy

Let us turn then to a critique of therapy as it now functions in the field of psychiatry. As you might expect, this presentation is based on the premise that psychiatric medicine, previously considered devoid of hope and therapy, now emerges as one with amazing realization of success in broad treatment, both immediate and potential.

Before listing certain facts concerning these advances in treatment, I digress a moment to consider the section entitled "Medicine" in TIME magazine, Vol. LXVII, No. 20, May 14, 1956. It contains an article, titled: "Psychiatry Changes Course," which is concerned largely with negative generalizations.

TIME is wrong. It was not a turn of 90 degrees to the right, the equivalent of a swing half the distance from the purely somatic to the purely functional. Psychiatry has been balanced between these two poles, in recent years closer to the functional, but utilizing a good balance between them. Psychoanalysis is a portion of psychiatry, a field of graduate study and treatment continued in the broad field of psychiatry, where wise and mature psychiatrists embrace the somatic as well as the functional in etiology and therapy.

Dr. Percival Bailey, in an address before the May 1956 meeting of the American Psychiatric Association, questioned certain advances in psychiatry. This questioning should not pass without challenge. There has been change in psychiatry; nearly every movement in it has definitely been progressive, productive of more prevention, better care and almost sure cure. Dr. Bailey should leave laboratories and operating rooms, and find out how people live, love and suffer. Then he would find many who are receiving as well as giving beneficial treatment in psychiatric medicine. Psychiatry deals with not a single pathologic disease process or entity, nor with a limited chemical deficiency. Anyone who seeks an Open Sesame type of solution is doomed to early and final disillusionment.

So let us return now to summarize what doctors and hospitals really are accomplishing today.

PSYCHOTHERAPY. — Psychotherapy, of course, is the foundation of all therapy, and an ingredient that is necessary even in the presence of a drastic somatic therapy. Psychotherapy is as ancient as history itself and, when properly utilized, has always been effective, is more effective today and will be even more so in the future. It alone is successful as a treatment of choice in psychoneuroses; it comforts and supports depressive episodes; an intensive form of psychotherapy is beginning to show definite effect in selected cases of severe schizophrenia. There have been great advances in knowledge concerning the dynamic forces producing mental and emotional disorders, and the skill of psychiatrists has grown proportionately, so that psychotherapeutic technics have become more specific and of wider applicability. Even group psychotherapy is proving to be of wide usefulness in many large institutions.

In this new era of psychiatry lies more than one unrealized opportunity. Our social setting today is grim indeed, with penal institutions filled with wrong-doers who are society's problems, too many of them unfortunately still at a particularly tender age. Their problems are commonplace with stories of hate, rejection, aggression, and violence against their fellowmen. The least of them obviously are characteristically unguided and uncontrolled, self-centered and woefully immature. The newspapers and magazines headline feature stories concerning the delinquent and the problem teenagers; the court dockets are packed, the social agencies swamped. This kind of social disorder, characterized by the aggressive tendencies which lead to war, and the unresolved competitive drives which do not conform sufficiently to the demands of the herd on the self, has its origin in the early maladjustment of man.

Much can be done by psychiatric medicine in studying out these problems in family and community life, and much is being done in those centers where professionally trained personnel is available. The children's clinics, the psychiatric staffs of social agencies, courts, youth centers or study centers, when they are properly staffed and function, may fully show massive statistical results of benefit to their community areas. Too often modern scientific approaches are blamed for the prevalence of these medicolegal problems; it is only because so little can be done with them in the face of inadequate numbers of inadequately trained persons to deal with them. Stop and reflect on the few persons you know who are working in this field; it is likely none could make a list of five.

Medicine must do much and make great strides in an effort to correct these serious social situations. It would take few millions indeed to encourage and train doctors, lawyers and socially skilled persons in other professions to enlist their interest here, as compared to the many millions now hopelessly expended. Psychiatry knows enough now about both the mind and matter of man to aid effectively in therapy at this point. Real advances have been made here, but only in widely scattered spots. New opportunity to achieve lies in almost every community.

ELECTROSTIMULATION.—Electroshock therapy seems to be the first rather dramatic new therapy in psychiatry. Introduced in the latter 1930s, originally developed for application to schizophrenia, electroshock therapy is now considered the treatment of choice in cases of involutional psychotic depressive reactions. Although slightly less effective, it is also applicable to other clinical syndromes manifesting depression or equivalent symptoms. Included here are manic-depressive depressions, schizoaffective depressions, and neurotic reactive depressions. It is quick and beneficial in quieting the overactive and agitated patient.

With practically no contraindications, except for severe general physical depletion and severe organ pathology in which any somatic insult might prove deleterious, it has a remarkable therapeutic potential. Experience with tens of thousands shows that the loss of memory after treatment courses is only temporary, and any signs of organic damage are rarely if ever reported. With the skill and precautions in its administration now well worked out, it is a suitable outpatient treatment measure.

Statistics vary tremendously, but all agree electroshock therapy is effective in shortening the duration of an episode of illness and of hospitalization. In 86 per cent of cases of involution depression, 80 to 90 per cent of manic-depressive depression, and 70 to 80 per cent of manic-depressive mania remission follows treatment, and in cases of schizophrenia of less than six months' duration, remission occurs in 68 per cent.

INSULIN THERAPY. — Insulin coma therapy has been used in the treatment of schizophrenia for nearly 20 years. The consensus is that it is

an effective agent in altering the immediate outlook in the disease. The main drawback of insulin coma therapy is its expense, since it requires a high number of personnel. At the Pennsylvania Hospital a follow-up on 781 patients treated showed 67 per cent improved or recovered after the three months' treatment; at five years and at 10 years 32 per cent remained improved or recovered. At 14 years, however, follow-ups showed this figure reduced to 20 per cent. In view of the fact that this therapy has failed to increase the number of relapse-free recoveries, we concluded that its main effectiveness lies in improving the immediate prognosis. This study indicated also the importance of continuous use of postinsulin therapies and psychiatric management in the family setting. The use of insulin coma therapy has been reduced somewhat in the past two years, because of the effect of newer drug therapies on some types of schizophrenia.

Psychosurgery. — In the field of psychosurgery, it is apparent that after 18 years of at times highly charged debate among psychiatrists, neurologists and neurosurgeons, "psychosurgical" procedures became established in the therapies used against psychiatric illnesses. After probably more than 30,000 operations in this country alone, interrupting more pathways of the brain has not become the panacea as championed by some, nor has is produced a grotesque horde of amoral automatons as feared by others.

Today, the transorbital lobotomy seems to be the method of choice. It still may be used, especially in the larger state hospitals for the mentally ill. Despite the remarkable changes for the better in treatment programs in our hospitals because of more and better trained personnel, and more effective somatic and drug therapies, there still will be some very ill patients who may not receive full benefit and may be selected appropriately for this treatment. The success of other therapies, however, is now becoming so much broader that it should be stated that lobotomies in 1956 are reduced in frequency at least 90 per cent.

Pharmacologic Preparations. — The real drama in psychiatric medicine erupted somewhat abruptly with the advent of the new medications, generally classified as the "tranquilizing drugs." In general medicine, some of them have been used for headaches, hypertension, nervousness, minor painful medical conditions and all psychosomatic states; included among these drugs are chlorpromazine, reserpine, and meprobamate. Thus they are becoming somewhat familiar to the general practitioner, who also is using them along with psychiatrists for some of the minor psychiatric syndromes. The greatest response, of course, has been in the larger state hospitals, even more than in the office practice of psychiatrists, but enough response is universally presented to direct attention to the fact that here is medication that is doing something in psychiatry to certain kinds of patients that other therapies have failed to accomplish in the same manner or to the same degree.

In general, these medications tend to reduce the state of tension, anxiety and worry. The violently disturbed patient is much more cooperative and follows the social or hospital program consistently under the direction of nurses. The patient suffering from depression in general does not seem to be benefited as much as by electroshock. Patients with obsessive compulsive syndromes experience a reduction in the tension and in the persistence of the obsessional thinking. In many kinds of clinical syndromes the patient becomes more accessible to personal contacts with psychiatrists and is much more successfully treated. This responsiveness perhaps is one of the most important effects of these drugs. They are important in therapy and management and in the control and hospitalization of patients with difficult psychiatric syndromes; also, they are equally valuable in the treatment of the acute disorders and in the office management of patients who have been given psychotherapy. This response means, therefore, that hospitalization of such patients will be pleasanter, and in some instances not necessary.

Progress in Clinical Psychiatry

What might be described as new or of special interest in clinical psychiatry now unfolded on this dramatic scene?

The most striking reports emanate naturally from those large state hospitals where hundreds of patients may be given new treatments at one period. The New York Times for Jan. 29, 1956, reported on results of the new drugs at Rochester State Hospital. ". . . . Disturbed patients are on good behaviour . . . iron bars are no longer necessary . . . floral draperies have gone up . . . patients use tools in occupational therapy . . . not all are cured . . . but some have gone home and back to work . . . or are for the first time in years amenable to conventional forms of psychotherapy . . . the nurses and the ward attendants are the ones who attest most to the change that

the drugs have brought about." The last phrase is one of greatest significance.

At the Galesburg, Illinois, State Research Hospital various speakers in September 1955 generally reported remarkable results for both short term and long term disturbed patients. Dr. Nathan Kline of New York estimated that 5 per cent of the present hospital patient census might be discharged if the drugs continued to have this effect consistently. A Pennsylvania state hospital, even with increased admissions in 1955, sharply reduced its percentage of overcrowding.

Despite this success with drugs, it is important to see what may happen in a large overcrowded understaffed hospital when other treatment measures are adequately provided. In one Kansas state hospital, before much of the new medication was in use, a revolutionary change was made by quadrupling the number of nurses and attendants, and increasing the psychiatrists tenfold, with concomitant increases in other personnel concerned with handling and treatment of patients. The cost per patient day increased from something less than $3.00 per diem to something in excess of $6.00 per diem. Almost all of this increase went to payroll expense for personnel. This hospital likewise showed dramatic results — not only humanizing all therapy, but the hospital census was reduced, the hospital average stay was amazingly shortened, and the whole atmosphere of the patient's life in that hospital was transformed.

In one of the best private nonprofit psychiatric hospitals, which has the highest number of doctors, nurses, and other personnel in ratio to number of patients treated, there are approximately 100 beds occupied by the acutely ill mental patients, with an annual admission of about 400 patients. This hospital provides all modern accepted forms of therapy, and is a training and clinical research institution. As a result its admissions and census figures show readily the real success or failure of any form of therapy. During the past two years the average stay of patients was obviously shortened, and the average daily census dropped over 10 to 15 per cent; yet the admissions increased over 10 per cent. This change may have occurred partly because of the new medications, but more on account of the fact that therapy of all kinds was definitely adequately available.

Obviously, both drug therapy and psychotherapy are important; each in its own way, under reasonably favorable circumstances, may appear to have wrought a miracle. Nevertheless, merely flinging pills about for patients to swallow will not solve the psychiatric problems today. We dread to think of the new drugs becoming the aspirin of psychiatry. There are new aspects in psychiatric treatment that must be kept in mind in viewing what is unquestionably a longitudinal problem in therapy.

In looking at these drugs from the general medical standpoint, I believe we should point out to doctors in general that they are not cures, that they may be able to attack or break up a condition, or abort the illness, but they do not necessarily add anything to the factors back of the illness nor correct maladjustment factors in the setting from which the person with the illness came. We have to do things in the hospitals and in the community of the preventive sort to correct conditions back of the origin of mental illness. We must aid general practitioners as well as our own students in psychiatry to apply these new treatments as assistants and modifiers. They provide accessibility to psychotherapy and are emergency measures and short term crutches. We must educate those outside the field of psychiatry who may be using, or who will use, these medications to know that these drugs are useful in addition to what they may be doing in the way of therapy, and are not to be abandoned just because by themselves they are not miracle drugs.

At least we can say, at this time, that these medications do affect new patients and old patients in new ways, and that we should have a constructive growth in both research and clinical progress that will add perhaps another 5 to 10 per cent of therapy to the whole field of psychiatry where we need it so much. They will not empty our hospitals, but they will aid us in treating better more patients, and in making our institutions better hospitals.

This extensive interest in drug therapy aspects of somatic therapy may be quite appropriate and timely. The continued research and study necessary here are obvious. Even more important, however, is acceleration, stimulation and restudy of the standard forms and practices of hospital therapies in general, as well as psychotherapy, both extramural and, especially, intramural.

This view was well stated by one of our elder statesmen of psychiatry but ten days ago. Let me quote from The Evening Bulletin of Philadelphia, of May 2, 1956, which reported on a paper pre-

sented at the Chicago meeting of the American Psychiatric Association:

Dr. Earl D. Bond, one of Philadelphia's elder statesmen of psychiatry, today urged a return to some of the ancient virtues that were practiced in mental hospitals a century ago but have been too often lost since.

They include kindliness and respect for the patient and enough space, doctors, nurses and attendants to give a patient highly individualized treatment.

Dr. Bond told the 112th Annual Meeting of the American Psychiatric Association at the Morrison Hotel (Chicago) that the public and the legislatures would be guilty if they let the new "wonder drugs" serve as an excuse for neglecting healing forces that have stood the test of time for 100 years.

"In the old days," he said, "doctors did not have the cold, objective poise in the presence of new ideas that we all possess now."

Dr. Bond pointed out that in 1857, the Journal of Insanity declared that any hospital where patients are "subjected to a machinelike, monotonous daily routine, denied all the occupations and amusement they need, falls far behind the spirit of the age."

A study of ten hospitals from 1844 to 1856 showed that there was no overcrowding and that there were adequate staffs and enough space for patients to be moved from one area to another as they improved. Occupational therapy was stronger than today.

"If we get rid of overcrowding, furnish adequate personnel, make it possible to show kindliness and respect for each individual patient," Dr. Bond said, "we have a basis on which to apply new methods of treatment with effectiveness and discrimination.

"The old therapeutic forces do not fight the new but can make them effective."

This might be termed a peculiar paradox — that specific somatic therapy is going to be the foremost aid to functional therapy. Yet patients who are benefited by these newer medications are almost demanding, perhaps not vocally, but nevertheless by implication, more attention, more to do, more opportunities to help themselves, more opportunities for personal growth. They are more clearly conscious; they are able to relate to each other, to their families, to the professional therapists attending them. Here is our main problem — training more persons for our clinics and hospitals, as well as activating therapeutic programs to be carried out by those now available — if we are to utilize adequately the new advantage we seem to have gained recently.

The important factor in the treatment of patients — of getting persons who are mentally ill well — is not shock or drugs, helpful though they are. It is personal — the hospital setting, the contact of personalities, the relationship with those trained in understanding the mentally ill, and the participation of all those who can help most through personal intimate constant contact.

Summary

In general as each somatic treatment has been discussed, its relative value has been pointed out, but to recapitulate, let us summarize again.

Today we may say that a few pharmacologic preparations are consistently altering mental and emotional conditions, primarily tension states, manic or agitated reactions.

We may say that electrostimulation, with many new refinements in technic, is more helpful specifically in depressive states, with fewer troublesome side effects.

We may say insulin therapy retards the illness or shortens hospitalization, aiding and abetting therapeutic endeavors in psychotherapy.

We may say psychosurgery has leveled from its overenthusiastic beginning, and in conservative hands may contribute a greater degree of mental health, peace and relaxation to patients with the most troubled clinical syndromes, when thoughtfully selected.

All of these somatic therapies might be designated as therapy for the organs or segments of man. Since man is a composite, this therapy is only fully effective when applied to the full existence of man, including the mind as well as matter, the total individual and his environment.

We must not become confused by the similarities in treatment results, regardless of type, now reported.

Difficulties in terminology, in measuring accurately, and in standards applied make our evaluation crude. We know, however, that patients do not stay in hospitals as long; they do not stay ill as long.

Regional differences and staffing problems in various-sized hospitals make one or another treatment procedure practical or impossible. Each of us must determine what treatment shall be best applied in each situation.

It is comforting to know that despite the similarities, results are worth while. In time, research will tell us more why and where, and establish contrasts which will be ever more challenging.

There are many here today who can share with me the good fortune of being able to look back on 30 years' practical experience in clinical psychiatry. It is interesting to see how well these 30 years may be divided into three parts:

The first 10 years, one needed to sustain a belief in therapy and its values.

The second 10 years were stimulated by the challenge of unique and new ideas in therapy; a new philosophy was becoming identified, both functional and somatic.

The third 10 years have been startling because responses and benefits have happened to

and for patients which definitely did not happen that way before.

Today, in psychiatry, I like what I see happening. I am confident and assured that it is good. Soon I hope to comprehend it better. I know now, more than ever before, that psychiatry is a field of positive therapy.

111 North Forty-Ninth Street.

Spontaneous Abortion

A Physician Speaks to His Patient

JOHN J. FISHER, M.D.
JACKSONVILLE

(In any gynecologic or obstetric practice the condition of abortion is a most common problem, especially as regards its satisfactory management — satisfactory, that is, from the viewpoint of the patient. This paper will add nothing to the store of scientific information concerning this condition. The purpose is solely to furnish a literary rather than a scientific adjunct to the practitioner, general or specialist alike, who includes the treatment of abortion cases in his practice. Without further apology, we turn to the consultation room.)

Mrs. Jones, on the basis of the history you have just given us and the findings of our examination just concluded, we have diagnosed your case as one of abortion. Let us hasten to assure you that we do not imply any criminal act on your part; nothing could be further from our intent. Your expression of resentment at our use of the term abortion is a natural one among the laity, who commonly employ the incorrect term *miscarriage* to denote spontaneous abortion, and reserve the term abortion for those cases of the induced, or criminal variety.

The term abortion, like so many medical terms, comes from the Latin, in this case the verb *abortare*. A liberal translation is "to detach from a site." We use the term to designate any pregnancy that is detached from its site in the womb and expelled, before it has developed sufficiently to have any chance of survival as a child. If development has proceeded to a stage where survival is possible, the term premature labor is chosen, whether or not the child actually survives.

Your case is one of spontaneous abortion, or one in which the symptoms have developed from some natural cause or causes, as opposed to the induced, or criminal, type of abortion. We further classify this condition into *threatened,* when there is still a chance for the pregnancy to continue; *inevitable,* when certain changes have occurred that are irreversible; and *incomplete,* when part of the pregnancy has been passed, but some yet remains in the womb. *Complete* abortion is sometimes used to designate the process upon its termination. Our management of this condition depends upon the stage present, and will be discussed later.

Incidence

First, we should like to discuss the incidence of abortion, or how often this condition actually occurs. Most likely, this is your first such experience, and it is natural for you to think that something may be wrong with you, that you cannot ever carry a pregnancy to term, and that your chances for a family are slim. The probability is that none of these fears has any foundation in fact, especially if you have previously carried a pregnancy full time.

We realize that you are not interested in statistics, and we might add that these are especially unreliable in the consideration of abortion for several reasons. Whenever one deals with so intimate a condition, the history obtained is not always reliable. This is especially true in the large dispensaries or clinics where so many statistical studies originate. Then, too, many early abortions go unrecognized, being regarded as late or irregular periods, and also many are forgotten.

A study from the Bureau of the Census shows a wide variation in statistical reports concerning the incidence of abortion, anywhere from one abortion to every 2.4 full term births, to one abortion to every 12.9 births, with an average of about one to five.

You are probably less interested in these studies from other cities and social groups than

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are we, as they may well seem inapplicable to your individual case. We, therefore, have pulled out of our files in this office the cards of 100 consecutive maternity cases, and have analyzed the past obstetric performances of the patients. If you had been in the office last year for maternity care, yours might well have been one of these hundred cases used for analysis.

In this group of patients, similar to yourself, there were 28 who had had four or more pregnancies including the current one. Nine of these 28 had never aborted, but 19, or slightly more than two thirds, had had at least one abortion.

In the histories of these patients there were recorded 82 full term and 12 premature labors, and 85 children were living at the time the study was made. In this same group there were 34 abortions, or a ratio of one abortion to every 2.41 full term deliveries in this office in patients with four or more pregnancies. You should realize from this study that abortion is not a rare occurrence, if this group of patients similar to yourself showed approximately four abortions for every 10 babies delivered.

Another fear you might naturally have is whether or not this experience means that all your pregnancies will end in abortion from now on. If you have had full term pregnancies in the past, you require but little reassurance that your next pregnancy will most likely be uncomplicated. If this is your first pregnancy, however, an elaboration of such reassurance is demanded.

An excellent authority points out in a large statistical study that there is little increased incidence of repeated abortion in women who have had one abortion, these patients being only 3.2 per cent more likely to abort than the woman who has not aborted before. Even after two consecutive abortions, we expect over 60 per cent of these patients to carry pregnancy successfully to term.

After three consecutive abortions, spontaneous cure occurs in only one out of six patients, however, and this group is classified as patients who habitually abort, and who deserve exhaustive study and enthusiastic treatment. It has been shown by several investigators that abortion occurs more frequently in couples with low fertility. In the women who abort after much delay and difficulty in becoming pregnant, the same attention should follow the first abortion.

To summarize the foregoing discussion on the incidence of abortion, we have shown you that the condition of abortion is not so uncommon among women as you might have thought; and that, unless abortion follows an infertility problem or occurs repeatedly, your chances of bearing children in future pregnancies are little affected by the diagnosis of abortion in your case at this time.

Causes of Abortion

It is natural that you next ask, "What causes abortion?" This question has been asked by physicians since the time of Hippocrates, and volumes of discussion have been written concerning the causative factors of this condition. The reason that much controversy exists is probably that the causes are multiple, varying with each case, and often more than one cause is present. There is little need to involve you in this medical controversy, as much of it rages over the rarer causes.

We agree with the idea that most abortions are the result of a defective pregnancy, and are really nature's way of getting rid of a fetus that would, if allowed to continue its development, result in a defective child. This thought is strongly supported by many observers who have carefully studied the products cast off at the time of abortion, and have found a tremendously high percentage of deformed pregnancies. Most of these evidence deformities that are not consistent with life.

Every man has a number of bad spermatozoa in his ejaculate. These are easily seen by looking through a microscope at a specimen of his product, and every report on the analysis of semen of normal males in our infertility studies has a certain percentage of abnormal forms. Likewise, we believe that every woman has a number of bad egg cells among the half million or so that are contained in her ovaries. When one of these defective eggs or one of these abnormal sperm cells is involved in a conception, rather than have a defective offspring result, nature rids itself of the undesirable product through the process of abortion.

This idea brings to mind a study performed in Boston several years ago, when the uteri (wombs) of a number of women were minutely examined following hysterectomy. Such examination is routinely made in all hospitals with somewhat less exactness; but what sets this study apart is the selectivity of the group. These were all women who required hysterectomy for reasons other than would be expected to interfere with conception, but which would make pregnancy dangerous, and these patients were all purposely operated upon near the end of their monthly cycle, just before the expected menstrual flow.

Detailed examination of the removed uteri revealed the presence of a pregnancy of a few days' duration in 12 cases. Of these 12 very early pregnancies, five, or 42 per cent, displayed abnormalities upon microscopic examination that were inconsistent with life. Thus, even before the first missed period, these pregnancies were scheduled for abortion. The series is too small to be of statistical significance, of course, but we believe it is close to the true percentage involved.

The higher percentage of this figure as compared to those abortions reported is most likely explained by the findings of another study, a few years back, at a large midwestern clinic. Here the menstrual flow products of the wives of the resident doctors were examined in connection with a basal temperature study. The examiners were surprised to find a strikingly high incidence of evidence of pregnancy aborting at the time of the expected menstrual period, with not the slightest suspicion on the part of the aborting mother. Often a patient with an infertility problem will be found to have no trouble conceiving, but she aborts at this early time at each conception, and never recognizes pregnancy.

There is a small group of abortions, very small, however, that is caused by trauma or injury. The trauma can be either physical or emotional. To be considered secondary to this cause, the other more common factors must first be eliminated, as many pregnancies are carried successfully despite severe shock, and as traumatic experiences are not so rare in life today but that one or more such instances can usually be found if searched for long enough.

Finally, we come to that small percentage of abortions in which constitutional factors are involved. These comprise a majority of our special cases of habitual abortions, and abortions following periods of infertility as mentioned previously. Fortunately these are few, but they deserve much attention, as they are the occasional cases in which we believe that we can accomplish something by means of therapy available to us at present.

Status of Child

With this talk we have probably raised a new fear in your mind. Our statement that the vast majority of abortions are processes whereby nature rids herself of defective pregnancies might well cause you to ask yourself, "If my pregnancy continues after my having threatened to abort, will my child be a normal one?" Rather than allow you to nurse such a thought to any degree of maturity, we might better digress for a moment to dispel any such fear.

Several studies have been reported in the medical literature which were based on a comparison between thousands of cases of threatened abortion with the pregnancy then carried to term and similar thousands of cases of term pregnancies in which no abortion had threatened during pregnancy. No increased incidence of deformed or abnormal children was found in those cases in which there had been threatened abortion. We believe, therefore, that a defective pregnancy will abort despite all measures, and a good conception will be most likely carried by you with a little aid.

Management

We now come to consideration of the management of your case. It is essential that you understand the philosophy of our treatment. This is based upon the causes of abortion as just discussed, but also upon another most important fact.

Examination of the expelled products of conception, and observation of many cases of abortion clinically, have shown that the development of pregnancy usually ceases at least several days, and often several weeks, before any bleeding is evident externally. It is not a rare occurrence to examine a patient we have seen at a very early visit for the diagnosis of pregnancy, and find upon subsequent re-examination an arrest of the development of her pregnancy, as evidenced by a failure of the womb to increase in size. There is no spotting reported, but our notation on the patient's chart at that time to suspect abortion is usually borne out by a call a week or so later that she is spotting and fears that she is threatening to abort.

For the double reason, therefore, that most abortions are nature's purge of poor pregnancies, and that most abortions have already become irreversible by the time bleeding has appeared, our management is of necessity conservative.

Therapy consists of bed rest, for its conservation of blood loss as much as for its supportive benefits, and mild sedation, to help make enforced idleness more acceptable. The patient need not be a complete invalid, and may get up for the requirements of elimination, but anyone bleeds less when quiet. There is little occasion for hospitalization unless the bleeding exceeds that of the height of the normal menstrual flow, or unless tissue is passed and bleeding continues. Anything passed that look like tissue should be saved and the physician notified. Women had

abortions before there were hospitals, and many can still be conducted in the home through all or most of their course.

Your abortion, which is now in the stage of threatened abortion, will terminate in one of four ways. We hope that the spotting will cease, and that the pregnancy will continue without further incident and result in the delivery at term of a normal child. In short, your abortion may never pass beyond the threatened stage.

The other possibilities all concern progression of the abortion process to the loss of pregnancy. This may be mild and prolonged; in which case the vaginal bleeding will remain relatively small in amount, continue for many days, gradually lessen into a brownish discharge, and finally terminate in a succeeding menstrual flow.

More likely, the course of abortion will prove more dramatic and display a pronounced increase in bleeding and the appearance of cramping, which increases until tissue is passed. If this is the complete product of pregnancy, the cramps will be relieved almost immediately and the bleeding will slacken decidedly. Recovery is similar to that following term delivery, and the process has been described as labor in miniature, although the pain may sometimes approach and occasionally exceed that of term labor.

If only part of the pregnancy is passed, the bleeding will continue until the remainder of the conception is scraped from the wall of the womb. This procedure is what we call a curettage, or popularly a "D&C." It is an operating room procedure and requires an anesthetic, but there is no incision and only a day or two of postoperative hospitalization as a rule.

We must be certain that your pregnancy cannot possibly continue before we scrape out the uterus, as it is essential that a normal pregnancy not be disturbed. The passage of pregnancy tissue is proof that pregnancy is being expelled, and is required before active intervention in all cases, except the exceptional case in which bleeding is so severe as to threaten the patient. It is important, therefore, that any tissue passed at home be saved, as this is evidence that may avoid a needless loss of time to acquire again.

The use of hormones in abortion is debatable. Certainly they are of value in hormone-deficient cases only, which often are encountered when there are low fertility problems and when the patient habitually aborts. The results of their use in such cases are best when the hormone therapy was started prior to the occurrence of pregnancy, and when prescribed on the basis of clinical study, rather than being given just because a woman threatens to abort. Besides, hormones are too expensive and too dangerous for indiscriminate use.

We trust you will reassure your family concerning the essentials we have touched upon, and especially on the matter that you are not being neglected. Cases of abortion are not the most satisfactory. The patient is unhappy because she might lose her pregnancy; the husband is unhappy because his wife is ill, and there might be hospital and surgical bills with no baby to show for them; the family is unhappy because they think that not enough attention is being given their daughter; and the doctor is unhappy because he has little effective therapy to forestall the progression of abortion from the threatened to the later stages. Even if he believes abortion has occurred and nothing can be gained by further delay, he can do nothing unless some tissue is passed.

Conclusion

In conclusion, many of the points we have mentioned so briefly in this discussion are highly controversial, and final opinion concerning these has not yet crystallized. We do not pretend, moreover, to have given the final answer on this complex condition about which a small library has been recorded. Our discussion admittedly suffers from the sacrifice of detailed explanation for the sake of brevity, and the trade of more exact scientific terminology in return for increased readability. We do hope, however, that for all its faults, our talk has enabled you to understand better the problem of abortion in general and, more specifically, as it affects you.

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Discussion

Dr. Max Suter, Jacksonville: Dr. Fisher has beautifully and completely covered the subject of abortions as the physician will present this problem to his patient. I will present a few thoughts which occurred while I was going over this paper.

The incidence of abortions which the essayist found both in the literature and in his series amazed me. I re-

viewed the histories of 430 of our patients, not including their present pregnancy, and found that these patients had 161 abortions out of 704 pregnancies, an incidence of 23 per cent. Believing that these figures might be weighted by the fact that these were all the records of obstetric patients who had been delivered, I reviewed the records of 100 patients who came to the office for any stage of pregnancy. Fifty-two abortions were reported among 226 pregnancies, an incidence of 23 per cent.

Dr. Fisher quoted Mall and his co-workers and Hertig and Rock, who stressed the high incidence of defective pregnancies among the abortuses. Kaeser[1] studied 606 abortions in Switzerland and found the causes to be ovular in 35.4 per cent, maternal in 29.2 per cent, criminal in 24.8 per cent and uncertain in 10.6 per cent. Of these patients 10.4 per cent habitually aborted, that is, had had three or more consecutive abortions.

Habitual abortions deserve special consideration in any paper dealing with this subject. A high rate of abortions in future pregnancies can be predicted in this group. The essayist quotes the fact that only one pregnancy in six will be successfully carried to term in patients who have had three successive pregnancies. Javert, Finn and Stander[2] found 55.5 per cent of all who habitually abort will do so again without treatment. In a review of 100 patients with habitual abortions Wall and Hertig[3] found that 43 per cent were due to ovular causes and 15 per cent to maternal causes. Patients who have had three or more successive abortions have been treated by the use of vitamin C and vitamin K, abstinence from intercourse, avoidance of mineral oil, ordinary ambulation, psychotherapy and elimination of gynecologic diseases with a 90 per cent salvage rate reported by Javert and his associates.[2] According to the figures which were considered before, we should only be able to save 57 per cent of these pregnancies because 43 per cent of the conceptuses would be abnormal. This brings up the inevitable conclusion that the simple regimen recommended by these authors does something to the body which affects the conceptus in a beneficial manner.

It is difficult to improve on the analysis of 1,570 consecutive cases of threatened abortion by Colvin, Bartholomew, Grimes and Fish.[4] They found that 28 per cent of the patients in this series aborted, 2.1 per cent had premature babies, and 69.9 per cent continued to term. Of the aborted ova, 72.2 per cent were blighted. Of 112 patients whose threatened abortion terminated in the expulsion of a blighted ovum, the next pregnancy went to term in 86.6 per cent. This rate compares favorably with the abortion rate previously pointed out. These authors made the interesting observation that of the 452 patients in whom the initial bleeding was brown, 55 per cent aborted; of 1,000 patients whose initial bleeding was bright red and often considerable, only 10 per cent aborted; and of the 117 patients whose initial bleeding was a mixture of brown and bright red blood, 60 per cent aborted.

The total incidence of abnormal babies is 0.6 per cent according to Titus.[5] Burge[6] found that 0.92 per cent of the babies in 12,000 deliveries had major defects. Major abnormalities occurred in 1.5 per cent of the 800 babies born of patients with a threatened abortion. These figures showed only a slight increase in abnormal children in pregnancies with threatened abortions.

The relationship between Rh incompatibility and abortions is frequently brought up by patients. Glass[7] found that the incidence of abortions in 2,500 Rh positive women was 13.56 per cent; in 1,155 Rh negative nonsensitized women it was 13.2 per cent; and in 209 Rh negative sensitized women it was 15.25 per cent, indicating that there is no significant increase in abortions in sensitized Rh negative women. It is probable that abortions can be responsible for production of Rh antibodies.

The treatment, as Dr. Fisher stressed, is dependent on getting the cooperation and understanding of the patient and her family. We have also ceased putting much faith in various types of hormones in our practice. I believe that bed rest and sedation are the sheet anchors for threatened abortions. If bleeding is prolonged or excessive, dilatation and curettage are certainly indicated. I am convinced that the treatment of threatened abortions begins with good nutrition and an adequate understanding of the physiology of pregnancy.

I want to thank Dr. Fisher for a timely and excellent paper by which we have all benefited greatly.

Mental Health Services in County Health Departments in Florida

W. LANEY WHITEHURST, M.D., M.P.H.
JACKSONVILLE

Any over-all plan for the integration of mental health services into the existent health activities of a county health department will have to be extremely flexible because of the great variations found in population, area served, social and environmental conditions, local needs, available facilities and services, and individual limitations of the local health department staffs.

At the outset, let me explain that we in the Bureau of Mental Health have no intention of superseding, replacing, interfering or competing with the functions or the services now being provided by any legally constituted agency, profession or group in the field of mental health in Florida. Rather, it is our intention (1) to assist in the maintenance and/or improvement of the professional quality of the existing services; (2) to cooperate with, support and utilize existing professional facilities and personnel, augmenting them when necessary in so far as possible; (3) to continue in our efforts to make preventive medically and psychologically orientated mental health services more readily available to all the citizens in Florida, and (4) to support and stimulate the establishment and growth of accredited training facilities for all mental health disciplines.

Director, Bureau of Mental Health, Florida State Board of Health.
Read before the Annual County Health Officers Meeting, Florida State Board of Health, Feb. 12, 1955, Jacksonville.

Services for the hospitalized mentally ill and emotionally disturbed patients in Florida are provided by the State Mental Hospitals, five or six county or municipal hospitals and a number of private hospitals. Services for the nonhospitalized patients are provided for by approximately 85 to 90 psychiatrists in private practice. About one half of these are located in the vicinity of Miami; one fourth of them are in the Tampa–St. Petersburg area. The remaining 20 or 25 are located in the other 14 most densely populated counties. This distribution leaves approximately 48 to 50 counties, or about one third of our population, without mental health services except for the efforts of some general practitioners, the county health departments, workers in the welfare agencies, or local school personnel and other interested persons or groups.

Bureau of Mental Health Program

The Florida State Board of Health, through the efforts of the Bureau of Mental Health and in cooperation with local medical societies, public schools, and other public-spirited groups and organizations, has attempted to augment the existing facilities by the establishment of clinics for the purpose of providing a preventive mental health service of an educational, diagnostic, counseling and child guidance nature in the most populous areas of the state.

In some areas, these clinics are completely integrated into the county health department. In most instances, this is not the case. In each instance, however, at least a part of the financial support is provided by the Bureau of Mental Health through the County Health Department's budget. From an economic point of view, and because of the scarcity of qualified personnel, it is impossible to establish a clinic in every county or health department. In fact, we have about reached the saturation point for additional clinics at this time. Primarily, we are now devoting our efforts to improving the quality and quantity of services given by these clinics.

As stated, there are some 40 to 50 counties in which mental health services for nonhospitalized patients are almost nonexistent. By designating certain of the clinics as consultation centers, adding to their staffs such personnel as are required to carry the additional supervision and patient load, and assigning a mental health worker to the rural county health department as a regular member of the staff, we hope to be able to offer a professional mental health service of a consultative, diagnostic and preventive nature to these rural areas.

These workers are to serve as sources of information on existing mental health services and facilities and will assist in the referral of persons in need of mental health services. They will carry on a program of mental health education working with interested groups and individuals. They will work closely with parents, teachers, nurses, physicians, and the courts in providing help for those in need of the services outlined. The mental health worker will receive professional guidance and supervision from the staff of the Bureau of Mental Health and will secure clinical supervision and assistance from the nearest mental health clinic. The clinic staff will be augmented to provide for this additional work load from surrounding counties.

Another major function of these workers, working under the direction of the county health officer and with the public health nurses on the staff, will be (1) to provide state mental institutions with information concerning patients committed to these institutions, (2) to work with the families of patients who have been committed to these institutions, and (3) to assist in supervising these patients while at home from the hospital on furlough or following discharge.

The new drugs now being used in the treatment of mental illness along with improved psychiatric technics will make it possible for mental institutions to discharge many patients who formerly required prolonged hospitalization. The course of the patient following release from inpatient care will be greatly aided if there can be a continued follow-up of his adjustment outside the hospital until final discharge. This program was authorized on a limited basis by the last session of the legislature, and two of these workers are now on duty and one is being oriented. Negotiations are under way for a fourth. One of these workers has a background of teaching and medical social work, two have training and experience as public health nurses, and the other is a psychiatric social worker.

The response of the communities they serve has been most enthusiastic, and we are receiving more requests for this type of service than we can provide. We are requesting a great increase in the number of these workers for the next biennium.

In summary, the demonstration project has proved to be highly popular and we believe successful as well. This now appears to be a practical

method of providing mental health services to small counties and increasing services in other counties.

The Florida State Board of Health has been designated as the Mental Health Authority for the State of Florida. This implies that the county health departments have certain responsibilities in mental health at the local level. There are 67 counties in Florida varying in population from approximately 3,000 to 750,000. All counties with the exception of St. Johns have full time health departments under the direction of physicians especially trained in public health and preventive medicine.

These county health departments are now engaged in performing certain activities in the tuberculosis program and other programs that are identical to those needed in carrying out a mental health program. Most of the health department professional personnel require little or no additional specialized training in mental health technics to perform such activities as:

(1) Through counseling with the family, to help them accept the patient's illness
(2) To help the patient and family understand the meaning of "furlough"
(3) While the patient is still hospitalized, to find out if the family is ready to accept the patient back in his home
(4) To serve as a liaison person in channeling information to and from the hospital, the patient, the family, and the family doctor
(5) By close interagency cooperation, to assist the individual patient by the integration of local mental health services and various agencies which might be involved in his rehabilitation or treatment, such as courts, welfare agencies, schools and family physicians
(6) To help the family to know and understand the implications of legal commitment and help regain, for the patients, their civil rights
(7) To help the patient and family to know what articles to take to the hospital and what to send
(8) To let the patient and/or the family know that they are personally interested in him and attempt to be helpful persons within the limits of their abilities
(9) To help the family better understand the patient and the necessity for continued patient-family contact
(10) To assist the patient's family in understanding that a great part of the patient's complaints and statements are due primarily to the patient's illness and do not necessarily represent his true opinions and feelings
(11) To help the patient's family cooperate with those professionally responsible for the patient's active treatment and care
(12) To help the family assist the patient to return to society

If the public health nurses and/or health officers are given an orientation at the Florida State Hospital, and some brief inservice training, they would be competent in:

(1) Helping the family understand the needs and benefits to be derived from hospitalization
(2) Explaining to the family, and sometimes to the patients, the purpose of the hospital's admission procedures
(3) Following up on medications, as ordered by the hospital, private practitioner and clinics (drugs, such as insulin, reserpine, Miltown, chlorpromazine and Frenquel)
(4) Helping the patient and/or family to assume their rightful responsibilities to each other upon the patient's return to his home
(5) Helping in the preparation of clinical records and reports
(6) Helping to interpret the treatment and diagnosis to the patient's family
(7) Being able to recognize some of the early symptoms of mental disease
(8) Being able to steer the patient to receive preventive care, utilizing local facilities and resources if available

These activities represent an expression of some needs for services that the Florida State Hospital has recognized and believes we in the public health field may be able to satisfy. They represent activities in the areas of:

(1) Precommitment procedures and services
(2) Parole and post release follow-up of cases
(3) Case history and clinical information gathering
(4) Liaison services and activities

It is recognized that in some instances certain persons on the staffs would need more extensive information and intensive training in basic personality structure and personality dynamics than others. This need would depend to a great

extent on individual background, training and experience.

Through the cooperative efforts of the staff of the Florida State Hospital, the Bureau of Mental Health and the Division of Public Health Nursing of the State Board of Health, a 48 hour orientation program has been instituted at the hospital in Chattahoochee. This program is similar to the orientation given public health nurses in the Tuberculosis Hospitals.

Our first group participated in this orientation in October of 1955. This group included not only public health nurses but also county health officers. Another group is scheduled for January 18-19 and plans are being made for a third group in March. We are planning to proceed with the orientation of Public Health Personnel in much the same manner as with the Tuberculosis Hospitals. At this time, considerable attention is being devoted to the study and evaluation of these visits so that we can determine what additional training may be necessary.

Services in Demand

In addition to the expression of needs from the hospital, there have been requests for these same services from local groups and agencies for some time. In fact, I find the suggestion made in the 1952 minutes of the Northeast Florida Mental Health Association's annual meeting that the health departments be requested to provide such a service.

Numbers of local communities have also expressed the need for referral services, educational services, and the liaison services with the schools, clinics, welfare agencies, rehabilitation offices, courts, local government units, medical societies and other groups in the field of mental health.

The county health departments have already proved themselves capable in the prevention and control of diseases. Public health departments have begun the elimination of the two most serious causes of mental illness, syphilis and pellagra. The county health departments are now working cooperatively with patients and hospitals, families of hospitalized patients (tuberculosis), the medical profession, welfare agencies, local governmental agencies, courts, schools and other groups. They have the experience and the "know-how." With a minimum of technical orientation, training and support, they could perform these same services in the field of mental health much more economically than would be required if a separate agency were established.

Box 210.

Camphor Poisoning

Report Of Case Occurring During Pregnancy

William P. Blackmon, M.D.
and
Hiram B. Curry, M.D.
Jasper

Camphor poisoning has been reported more than 130 times in medical literature,[1] but the frequent presence of camphor containing substances such as liniments and insect repellents suggests that its accidental ingestion is probably more frequent than this number would indicate. Furthermore, most of the reported cases occurred during the nineteenth century. Poisoning has usually followed accidental ingestion, but has been reported after the use of nose drops[2] and after intraperitoneal injection.[3]

Camphor has been used for centuries in Chinese medicine. Its odor probably led to its medical use and the reputation it enjoys even today among some of the laity as a valuable agent for protection against infection.[1]

The pharmacologic action of camphor is stimulation of the central nervous system, and in large doses it produces epileptiform convulsions. The literature on the cardiovascular actions of camphor reveals some disagreement. The blood pressure may fall because of peripheral vasodilatation, or rise slightly because of central vasomotor stimulation.[4] Camphor is probably detoxified in the liver by uniting with glycuronic acid and may appear in the urine as camphoglycuronic acid.[5]

The pathologic effects of camphor upon the brain have been well described by Smith and Margolis,[1] who demonstrated neuronal necrosis in a fatal case of camphor poisoning in an infant. They reproduced these changes in experimental studies in mice and demonstrated that in these

animals barbiturates not only prevent convulsions but also protect against neuronal damage. Other studies demonstrated fatty changes in the liver and kidneys.[6]

Report of Case

This is a report of severe camphor poisoning occurring during pregnancy with subsequent recovery and delivery of a normal infant. A 32 year old white multipara was hospitalized on Oct. 8, 1955, during her third month of gestation with a threatened abortion, manifested by uterine cramps and bleeding. Two days later she was accidentally given 45 cc. of camphorated oil, instead of mineral oil as ordered, by a nurse's aid. The patient vomited several times almost immediately, then had a convulsion and became unconscious. She had three subsequent convulsions. Treatment with oxygen, pentobarbital sodium and gastric lavage was immediately instituted, and she responded promptly to therapy. She regained consciousness after an hour, and there were apparently no further ill effects except for a persistent nausea for several days. The patient subsequently delivered a normal infant on March 31, 1956.

Summary

A brief review of camphor poisoning is presented, and a nonfatal case occurring during pregnancy is reported. The role of the barbiturates in the treatment of this intoxication is of especial interest.

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Curry-Blackmon Clinic.

ABSTRACTS

The Thyroid Gland in Relation to Obstetrics and Gynecology. By H. Clinton Davis, M.D. Section I of Chapter XX, Volume II, The Glands of Internal Secretion, in Davis' Gynecology and Obstetrics, W. F. Prior Company, Inc., Hagerstown, Md., 1956.

This comprehensive article is a part of the chapter on the glands of internal secretion in Davis' Gynecology and Obstetrics. It covers well the various aspects of the subject of the thyroid gland in relation to obstetrics and gynecology. The embryology, biochemistry and physiology of the thyroid gland, thyroid-endocrine interrelationships and clinical diseases of the thyroid are discussed. Also discussed are nontoxic goiter, toxic goiters, hyperthyroidism, hyperthyroidism and pregnancy, hypothyroidism, thyroiditis and cancer of the thyroid gland.

The Management of Acute Gastroduodenal Hemorrhage. By Timothy A. Lamphier, M.D., William Wickman, M.D., Samuel White, M.D., and Irving Gilbert, M.D. Am. J. Surg. 91:786-790 (May) 1956.

In handling the problem of massive upper gastrointestinal hemorrhage, the authors aim to judge or select for surgery those patients who will not respond to medical management and who will die unless there is surgical intervention. They discuss the problem from the standpoint of differential diagnosis, initial preparation, anesthesia and preoperative preparation, emergency surgery and surgical procedure, emphasizing certain clinical facets in an attempt to provide a workable program for massive gastrointestinal bleeding. They observe that a salvage rate of 100 per cent can be assumed if only one case of massive bleeding is rescued by surgery and that, for the best results, early decision for surgery will bring about much greater success, thus supporting the original contention of Finsterer. In their opinion, surgery is the decision of choice in that group of patients having more than one episode of massive bleeding, and, as emphasized by Dunphy, repeated syncope is the single most important symptom relative to early surgery. They stress the importance of the combined teamwork approach, utilizing the internist, roentgenologist, surgeon and anesthetist concurrently, to reduce the over-all hospital mortality for this dread condition.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprints, please lend us your copy of the journal containing the article.

Convention at Hollywood

May 5, 6, 7, 8, 1957

THE HOLLYWOOD BEACH HOTEL, WHERE THE CONVENTION IS BEING HELD; ITS POOL AND PRIVATE BEACH.

Out-of-State Convention Speakers

Dr. Ernest B. Howard, Assistant Secretary of the American Medical Association, Chicago, who will present an address on "National Socio-Economic Issues Confronting Medicine" during the General Session scheduled for Monday morning, May 6, in the Pageant Room.

Dr. Thomas Findley, Research Professor of Medicine for Cardiovascular Diseases at the Medical College of Georgia, Augusta, who will discuss "Diuresis and Antidiuresis" during the General Session on Monday morning, May 6. Dr. Findley will also serve as moderator for the Panel on Cardiovascular Surgery scheduled for the First Scientific Assembly Tuesday morning.

Dr. J. R. Heller, Director of the National Cancer Institute, Department of Health, Education and Welfare, National Institutes of Health, Bethesda, Md., who will deliver an address on "Progress in Cancer Control" during the General Session Monday morning, May 6. Dr. Heller will also serve as moderator for the Panel on Cancer scheduled for the Second Scientific Assembly Tuesday afternoon.

Lemuel W. Diggs, M.D., Guest Speaker

Dr. Lemuel W. Diggs is a Virginian by birth and a Tennessean by adoption, having been a Memphian for a quarter of a century. Born in Hampton, Va., in 1900, Dr. Diggs spent his early years in his native state and also received his academic training there. He was awarded the degrees of Bachelor of Science and Master of Arts by Randolph Macon College. For his medical training he chose the Johns Hopkins University School of Medicine, where he received the degree of Doctor of Medicine in 1926.

After spending three years in postgraduate work in medicine at the University of Rochester's Strong Memorial Hospital in Rochester, N. Y., Dr. Diggs joined the staff of the University of Tennessee College of Medicine as a pathologist. Later he transferred to the Division of Medicine as a Professor of Medicine and Director of the Department of Medical Laboratories for the University of Tennessee and City of Memphis Hospitals. For two years he was the clinical pathologist for the Cleveland Clinic Foundation in Cleveland, Ohio. He is now a consultant to the Tennessee Valley Authority and to the Armed Forces Institute of Pathology in Washington, D. C.

Locally, Dr. Diggs takes an interest in community activities. His principal hobby is farming.

A member and a former vice president of the American Society of Clinical Pathologists, he is also a member of the College of American Pathologists and the International Society of Hematology. At present, he is chairman of the Council on Hematology of the American Society of Clinical Pathologists. He also holds membership in the American Medical Association and the Southern Medical Association.

The principal research in which Dr. Diggs has engaged has been in the fields of clinical pathology and hematology. He has written many articles on sickle cell anemia, his chief interest. He is the author of a new text entitled "Morphology of Human Blood Cells." His laboratory manual, bearing the title "Laboratory Procedures Used at the John Gaston Hospital," is widely used throughout the South. For the last three editions of Miller's "Textbook of Clinical Pathology" he has served as the co-author. In addition, he has contributed to "Current Therapy" and Gould's "Medical Dictionary."

PROGRAM

Eighty-Third Annual Meeting

FLORIDA MEDICAL ASSOCIATION

Hollywood Beach Hotel
Hollywood

May 5, 6, 7, 8, 1957

General Information

Registration

The Registration Desk, located in the lobby of the Hollywood Beach Hotel, will be open Sunday, Monday and Tuesday 8:30 a.m. to 5:30 p.m. and Wednesday 8:30 a.m. to 12:30 p.m. Each member will be required to register and obtain an identification badge before attending any sessions. Guests and ladies are required to register also. There is no fee. Printed programs will be available at the Desk.

Convention Headquarters

Headquarters will be the Hollywood Beach Hotel where most activities are scheduled. Specialty groups approved by the Board of Governors will also hold their meetings concurrently.

Blue Shield

Blue Shield's annual meeting is being held at 4:00 Monday afternoon in the Pageant Room. There will be no conflict with other meetings, and all delegates seated at the First Session of the House of Delegates on Sunday are urged to attend. Delegates are active members of Blue Shield.

Videclinic

A special feature Monday afternoon beginning at 3:00 is the closed circuit television panel program originating in Chicago. Viewers in the Hollywood Beach Hotel theatre where Dr. Robert J. Needles, of St. Petersburg, will be moderator may submit questions by telephone to the panel. Physicians in Oklahoma, Louisiana, Kansas and North Carolina attending their annual meetings will also have a part in the program.

Hotels

Physicians attending the meetings and who desire reservations in hotels other than the Hollywood Beach should contact the Association, P. O. Box 2411, Jacksonville.

Golf

The Florida Medical Association Golf Tournament will be held on the Hollywood Beach Hotel Golf Course May 5-6. Dr. Curtis D. Benton Jr., of Fort Lauderdale, is chairman of the Golf Committee. Assisting him are Drs. Robert U. Moersch, Mark Butler, Russell R. Hippensteel and Walter S. Williams.

Competition will be for the Orlando Loving Cup (low net) and the Duval County Society Trophy (low gross). Dr. Arthur H. Weiland, of Coral Gables, won the Orlando Loving Cup at the Tournament in Miami Beach last year. Dr. Julian A. Rickles, of Miami, won the Duval Trophy.

Members of the Woman's Auxiliary will hold their annual tournament at the same course. They will have a separate list of prizes including the Orange County Medical Society trophy for low gross.

Those desiring further information should contact Dr. Benton.

Anglers

Physicians interested in fishing should contact the Hotel's Superintendent of Services or the Bell Captain, preferably the night before their planned trip. Rates for six persons are $45 for a half day or $75 for a full day. Bait and tackle are provided. The hotel will prepare lunch for those registered without charge. Large parties requiring several boats should make reservations in advance by writing Dr. Charles L. Wadsworth, 1404 S. Andrews Ave., Fort Lauderdale. Dr. Wadsworth is chairman of the Anglers Committee. Assisting him are Drs. Curtis H. Sory, Julius F. Boettner, S. Elliott Wilson and Lees M. Schadel Jr.

Florida Medical Committee for Better Government

The annual meeting and election of officers of the Florida Medical Committee for Better Government will take place Monday at a breakfast beginning at 8:00 a.m. A section of the main dining room will be reserved for the meeting.

County Society Presidents and Secretaries

Dr. William C. Roberts, President-Elect, has requested that the presidents and secretaries of all component county medical societies meet with him for breakfast Tuesday morning at 8:00. The meeting will be held in a reserved section of the main dining room.

The breakfast is an innovation on the program of the Convention this year. It was conceived by Dr. Roberts to "recognize the unselfish contribution to organized medicine by county medical society officers."

Patio Party

Dr. Scottie J. Wilson is chairman of the committee on arrangements for the Patio Party. This fellowship and cocktail hour scheduled for 7:00 p.m. Tuesday will be held at the hotel pool. Tickets will be available at the registration desk. Informal entertainment is being arranged.

Convention Committees

Anglers: Charles L. Wadsworth, Chairman; Curtis H. Sory; Julius F. Boettner; S. Elliott Wilson; Lees M. Schadel Jr.

Golf: Curtis D. Benton Jr., Chairman; Robert U. Moersch; Mark Butler; Russell R. Hippensteel; Walter S. Williams.

Greeters: Burns A. Dobbins Jr., Chairman; Donald H. Gahagen; Norris M. Beasley; Anthony C. Galluccio; Walter J. Glenn Jr.

Ladies' Advisory Committee: Wiley M. Sams, Chairman; William K. Peck; John R. Hege Jr.; James M. Weaver; Scottie J. Wilson.

Saturday and Sunday

May 4-5

Specialty Group Meetings

Rooms have been assigned to the various specialty groups in the Hollywood Beach Hotel. The Florida Medical Association is not to furnish projecting lanterns or any of the equipment necessary for the holding of such meetings.

FLORIDA ALLERGY SOCIETY

Edwin P. Preston, President — Miami
Norris M. Beasley, Vice Pres. — Fort Lauderdale
Harold Rand, Secy.-Treas. — Miami

Saturday, May 4

Hollywood Beach Hotel — Crown Club

Joint Meeting with the Florida Pediatric Society.

2:30 p.m. "Milk Allergy," Susan C. Dees, Associate Professor of Pediatrics and Pediatric Allergy, Duke University School of Medicine, Durham, N. C.

3:30 p.m. Panel Discussion
Susan C. Dees, Durham, N. C.; W. Ambrose McGee, West Palm Beach; Edwin P. Preston, Miami; Norris M. Beasley, Fort Lauderdale; Joel V. McCall, Daytona Beach, and Henry G. Morton, Sarasota

5:00 p.m. Cocktail Party jointly with Florida Pediatric Society, Courtesy of Mead Johnson & Co.

Sunday, May 5

Hollywood Beach Hotel — Crown Club

Joint Meeting with the Florida Pediatric Society

10:00 .m. "The Role of Allergy in Recurrent URI Problems," Susan C. Dees, Associate Professor of Pediatrics and Pediatric Allergy, Duke University School of Medicine, Durham, N. C.

11:00 a.m. "Treatment of Bronchial Asthma," Leon Unger, Associate Professor of Medicine, Northwestern University School of Medicine, Chicago

The lobby of the Hollywood Beach Hotel, headquarters for the Eighty-Third Annual Meeting.

FLORIDA SOCIETY OF ANESTHESIOLOGISTS

Harry E. Bierley, President — West Palm Beach
Stanley H. Axelrod, Pres.-elect — Miami Beach
Breckinridge W. Wing, Vice Pres. — Orlando
Edwin C. Northup, Secy.-Treas. — St. Petersburg

Sunday, May 5

Hollywood Beach Hotel — Windsor Room

10:00 a.m. Business Meeting and Election of Officers

FLORIDA CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Jack Reiss, President — Coral Gables
Clarence M. Sharp, Vice Pres. — Jacksonville
M. Eugene Flipse, Secy-Treas. — Miami
George L. Baum, Program Chairman — Coral Gables

Sunday, May 5

Hollywood Beach Hotel — Cinema

8:45 a.m. Business Meeting

9:10 a.m. "Preoperative Evaluation of the Geriatric Bronchogenic Carcinoma Patient," Charles F. Tate Jr., Miami
Discussion Leader: Asher Marks, Miami

9:40 a.m. "Serum Glutamic Oxaloacetic Transaminase, Serum Glutamic Pyruvic Transaminase and Serum Lactic Dehydrogenase in Myocardial Infarction," John S. La Due, New York City
Discussion Leader: J. Frederick Woessner, Miami

10:20 a.m. "Middle Lobe Syndrome," Harold C. Spear, Miami
Discussion Leader: DeWitt C. Daughtry, Miami

10:50 a.m. "Use of Extracorporeal Circulation in Open Heart Surgery," Robert S. Litwak, Miami
Discussion Leader: Philip Samet, Miami Beach

11:20 a.m. "Alterations of the Electrocardiogram in Neuropsychiatric Patients," A. A. Leonidoff, Poughkeepsie, N. Y.
Discussion Leader: Louis Lemberg, Miami

12:00 Noon Lunch

1:00 p.m. "Management of Pulmonary Tuberculosis"
Panel Discussion: Jack Reiss, Coral Gables, Moderator; Ivan C. Schmidt, West Palm Beach; Hawley H. Seiler, Tampa, and Simon D. Doff, Jacksonville

1:40 p.m. "Chronic Pulmonary Emphysema"
Panel Discussion: M. Eugene Flipse, Miami, Moderator; Philip Samet, Miami Beach; Asher Marks, Miami, and Jerome Benson, Miami

2:20 p.m. X-Ray Seminar, M. Jay Flipse, Miami, Moderator
Those in attendance are requested to bring x-rays for discussion after presenting a brief and pertinent clinical history.

3:00 p.m. Adjournment

FLORIDA ASSOCIATION OF DERMATOLOGY AND SYPHILOLOGY

Joseph A. J. Farrington, President	Jacksonville
Herman Glassman, Vice Pres.	Miami
Kenneth J. Weiler, Secy.-Treas.	St. Petersburg

Saturday, May 4

Place to be announced

6:30 p.m. Cocktail Party

Sunday, May 5

Place to be announced

10:00 a.m. Clinic

12:30 p.m. Luncheon

FLORIDA ACADEMY OF GENERAL PRACTICE

Leo M. Wachtel, President	Jacksonville
Henry L. Harrell, Pres.-elect	Ocala
Achille A. Monaco, Vice Pres.	Daytona Beach
Charles D. Cooksey, Secy.-Treas.	Jacksonville

Sunday, May 5

HOLLYWOOD BEACH HOTEL — PAGEANT S. ROOM

10:00 a.m. Board Meeting

8:00 p.m. Scientific Session
Topic to be announced. Bruce W. Halstead, Lt. (MC) USNR, Chairman, Department of Biotoxicology, School of Tropical and Preventive Medicine, College of Medical Evangelists, Loma Linda, Calif.

8:30 p.m. General Meeting

FLORIDA HEALTH OFFICERS' SOCIETY

Turner E. Cato, President	Miami
Warren T. Weathington, Vice Pres.	Apalachicola
Lorenzo L. Parks, Secy.-Treas.	Jacksonville

Sunday, May 5

HOLLYWOOD BEACH HOTEL — SPECTATOR ROOM

10:00 a.m. "Epidemic Protracted Debility—An Iceland Disease-like Illness Occurring in Punta Gorda, Florida, in 1956," D. A. Henderson, Atlanta.
Discussion: Joseph W. Lawrence, Arcadia

10:20 a.m. "The Hospital Program in Florida," Alvin D. James, Hospital Consultant, Florida State Board of Health, Jacksonville
Discussion: Thomas E. Morgan, Jacksonville

10:40 a.m. "New Concepts and Ideas in the Relationship of Viruses to Disease," Michael Sigel, Miami
Discussion: Nathan Schneider, Ph.D., Jacksonville

11:10 a.m. "Organization of a National Streptococcal Epidemiological Survey," Milton S. Saslaw, Miami
Discussion: Simon D. Doff, Jacksonville

11:30 a.m. Business Session

FLORIDA ASSOCIATION OF INDUSTRIAL AND RAILWAY SURGEONS

Herschel G. Cole, President	Tampa
Francis T. Holland, Pres.-elect	Tallahassee
William G. Harris, Vice Pres.	Jacksonville
John H. Mitchell, Secy.-Treas.	Jacksonville

Sunday, May 5

HOLLYWOOD BEACH HOTEL — CORONET ROOM

9:00 a.m. Business Session; Election of Officers
Scientific Session
"Injuries to the Hand," Daniel C. Riordan, New Orleans.
Joint Meeting with Florida Orthopedic Society

6:30 p.m. Cocktail Party jointly with Florida Orthopedic Society

FLORIDA SOCIETY OF NEUROLOGY AND PSYCHIATRY

Paul S. Jarrett, President	Miami
William H. Everts, Vice Pres.	West Palm Beach
J. Robert Campbell, Secy.-Treas.	Tampa

Saturday, May 4

HOLLYWOOD BEACH HOTEL—ESSEX ROOM

9:00 a.m. Business Meeting

2:00 p.m. Scientific Session
"Present Medico-Legal Status of the Electroencephalogram," William H. McCullagh and William Ingram Jr., Jacksonville
"The Psychiatric Emergency," Jess V. Cohn, Hollywood
(Title to be announced) Maurice H. Greenhill, Miami

6:00 p.m. Cocktails

7:00 p.m. Dinner

Sunday, May 5

HOLLYWOOD BEACH HOTEL—ESSEX ROOM

9:30 a.m. "Neuromuscular Reflex Therapy for Spastic Disorders," Temple Fay, Consultant in Neurosurgery, U. S. Naval Hospital, Philadelphia, and Philadelphia General Hospital

11:00 a.m. Business Meeting
(The breakfast meeting of the Woman's Auxiliary to the Florida Society of Neurology and Psychiatry will be held at 9:30 a.m. Sunday. Place to be announced)

The Pageant Room of the Hollywood Beach Hotel where meetings of the House of Delegates and the Scientific Assemblies are to be held.

FLORIDA OBSTETRIC AND GYNECOLOGIC SOCIETY

S. L. Watson, President — Lakeland
S. Carnes Harvard, Pres.-elect — Brooksville
T. Bert Fletcher Jr., Secy.-Treas. — Tallahassee

Saturday, May 4

Hollywood Beach Hotel

7:00 p.m. Social Hour

Sunday, May 5

Hollywood Beach Hotel — Pageant N. Room

9:00 a.m. Business Meeting

10:00 a.m. (Topic to be announced) Herbert E. Schmitz, Chicago, Guest Speaker

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FLORIDA SOCIETY OF OPHTHALMOLOGY AND OTOLARYNGOLOGY

Blackburn W. Lowry, President — Tampa
Carl S. McLemore, Pres.-elect — Orlando
Edson J. Andrews, 1st Vice Pres. — Tallahassee
G. Dekle Taylor, 2nd Vice Pres. — Jacksonville
Kenneth S. Whitmer, Secy.-Treas. — Miami

Sunday, May 5

Chrest Restaurant

9:15 a.m. Scientific Session
"Tympanoplasty," Juan Manuel Tato, Buenos Aires, S.A.
"Complications of Retinal Detachment Surgery," P. Robb McDonald, Philadelphia, Pa.
Annual Report of the Florida Council for the Blind, Mr. Harry E. Simmons, Executive Director
"Corrective Surgery of Nasal Framework," Richard T. Farrior, Tampa
Discussion: Maurice I. Edelman, Miami Beach
Chas. J. Heinberg, Pensacola
"Subluxated Lens," film presented by William J. Knauer Jr., Jacksonville
Discussion: Joseph W. Taylor Jr., Tampa
Business Session
Presentation of Past President's Key
President's Address, Blackburn W. Lowry, Tampa
Business Meeting
Election of Officers
Cocktail Party

FLORIDA ORTHOPEDIC SOCIETY

Newton C. McCollough, President — Orlando
Wendell J. Newcomb, Vice Pres. — Pensacola
Harry E. Beller, Secy.-Treas. — Miami

Sunday, May 5

Hollywood Beach Hotel—Coronet Room

10:00 a.m. Joint Meeting with Florida Association of Industrial and Railway Surgeons

11:00 a.m. Business Session

6:30 p.m. Cocktail Party jointly with Florida Association of Industrial and Railway Surgeons

FLORIDA SOCIETY OF PATHOLOGISTS

Wray D. Storey, President — Tampa
Theodore C. Keller, Vice Pres. — Miami
Clarence W. Ketchum, Secretary — Tallahassee
James B. Leonard, Treasurer — Clearwater

Saturday, May 4

Hollywood Beach Hotel — Spectator Room

2:00 p.m. Program to be announced

FLORIDA PEDIATRIC SOCIETY

Joel V. McCall Jr., President — Daytona Beach
Henry G. Morton, Pres.-elect — Sarasota
Burns A. Dobbins Jr., Secy.-Treas. — Fort Lauderdale

Saturday, May 4

Hollywood Beach Hotel — Crown Club

Joint Meeting with the Florida Allergy Society

2:30 p.m. "Milk Allergy," Susan C. Dees, Associate Professor of Pediatrics and Pediatric Allergy, Duke University School of Medicine, Durham, N. C.

3:30 p.m. Panel Discussion
Susan C. Dees, Durham, N. C.; W. Ambrose McGee, West Palm Beach; Edwin P. Preston, Miami; Norris M. Beasley, Fort Lauderdale; Joel V. McCall, Daytona Beach, and Henry G. Morton, Sarasota

5:00 p.m. Cocktail Party jointly with Florida Allergy Society, Courtesy of Mead Johnson & Co.

Sunday, May 5

Hollywood Beach Hotel — Crown Club

Joint Meeting with the Florida Allergy Society

10:00 a.m. "The Role of Allergy in Recurrent URI Problems," Susan C. Dees, Associate Professor of Pediatrics and Pediatric Allergy, Duke University School of Medicine, Durham, N. C.

11:00 a.m. "Treatment of Bronchial Asthma," Leon Unger, Associate Professor of Medicine, Northwestern University School of Medicine, Chicago

12:00 Business Meeting—Florida Pediatric Society

FLORIDA SOCIETY OF PLASTIC AND RECONSTRUCTIVE SURGERY

George W. Robertson III, President — Miami
Bernard L. N. Morgan, Secy.-Treas. — Jacksonville

Sunday, May 5

Hollywood Beach Hotel — Dance Studio

10:30 a.m. Business meeting and election of officers

An emergency hospital unit will be displayed on a vacant lot immediately south of the Hollywood Beach Hotel during the Association's annual meeting. Tentage will be provided by Company B, Florida National Guard, Fort Lauderdale. Physicians are invited to visit the unit.

FLORIDA PROCTOLOGIC SOCIETY

George Williams Jr., President	Miami
Ralph F. Allen, Vice Pres.	Coral Gables
Sam N. Sulman, Secy.-Treas.	Orlando

Sunday, May 5

HOLLYWOOD BEACH HOTEL — PARK LANE ROOM

5:00 p.m. Program to be announced

FLORIDA RADIOLOGICAL SOCIETY

James T. Shelden, President	Lakeland
Donald H. Gahagen, Vice Pres.	Fort Lauderdale
C. Robert DeArmas, Secy.-Treas.	Daytona Beach

Saturday, May 4

HOLLYWOOD BEACH HOTEL

7:00 p.m. Banquet

Sunday, May 5

HOLLYWOOD BEACH HOTEL — PARK LANE ROOM

9:00 a.m. Program to be announced

FLORIDA CHAPTER, AMERICAN COLLEGE OF SURGEONS

Frederick H. Bowen, President	Jacksonville
Julius C. Davis, Vice Pres.	Quincy
C. Frank Chunn, Secy.-Treas.	Tampa

Sunday, May 5

SURF HOTEL LOBBY

10:00 a.m. "Experiences in Radical Pelvic Surgery for Carcinoma of the Cervix," Cortlandt D. Berry, Orlando
"Ulcerative Colitis," Henry Cave, New York City

6:00 p.m. Cocktail party

FLORIDA UROLOGICAL SOCIETY

Frank J. Pyle, President	Orlando
Melvin M. Simmons, Secy.-Treas.	Sarasota

Sunday, May 5

HOLLYWOOD BEACH HOTEL — VOGUE ROOM

10:00 a.m. Round table discussion on Hematuria, Participants to be announced

5:30 p.m. Cocktail Party. Place to be announced

BLUE SHIELD OF FLORIDA

Russell B. Carson, M.D., President	Fort Lauderdale
George S. Palmer, M.D., Vice Pres.	Tallahassee
Hunter B. Rogers, M.D., Vice Pres.	Miami
John T. Stage, M.D., Secretary	Jacksonville
H. A. Schroder, Asst. Secretary	Jacksonville
Floyd K. Hurt, M.D., Treasurer	Jacksonville
Samuel M. Day, M.D., Asst. Treasurer	Jacksonville

Saturday, May 4

HOLLYWOOD BEACH HOTEL — PARK LANE ROOM

2:00 p.m. Board of Directors Meeting

Monday, May 6

HOLLYWOOD BEACH HOTEL — PAGEANT N. ROOM

4:00 p.m. Annual Meeting, Active Members
Annual Meeting, Board of Directors

FLORIDA CANCER COUNCIL

Ashbel C. Williams, Chairman	Jacksonville
Lorenzo L. Parks, Secretary	Jacksonville
Samuel B. D. Rhea	Pensacola
Alfred E. Cronkite	Fort Lauderdale
Paul J. Coughlin	Tallahassee
Wilson T. Sowder	Jacksonville
Chas. J. Collins	Orlando

Sunday, May 5

HOLLYWOOD BEACH HOTEL—ESSEX ROOM

8:30 p.m. Business Meeting

COLLEGE OF MEDICAL EVANGELISTS FLORIDA CHAPTER ALUMNI ASSOCIATION

Sunday, May 5

HIALEAH HOSPITAL

7:00 p.m. Regular Meeting

The Hollywood Beach Hotel golf course where the Florida Medical Association golf tournament will be held.

First Meeting House of Delegates

Sunday, 2:30 p.m.

Hollywood Beach Hotel—Pageant Room

Delegates assemble at the Credentials Committee table at the entrance to the Pageant Room at 2:30 p.m. to present their credentials, fill out attendance cards and receive special badges from the Credentials Committee:

Louis M. Orr, *Chairman*
Ralph W. Jack
Walter H. Winchester

Delegates are to occupy seats in the designated reserved section. Other members of the Association and guests are requested to occupy seats in the other sections of the room.

3:00 p.m., President Langley in the Chair

Parliamentarian for the President—George F. Schmitt Jr.

Number of eligible Delegates present. Report by Louis M. Orr, Chairman, Credentials Committee

Motion to seat Delegates if a quorum is present

Approval of minutes of 1956 annual meeting published in July, 1956 Journal

Adoption of minutes of called meeting Nov. 4, 1956, published in February, 1957 Journal

Gavel to First Vice President, Meredith Mallory

President's Address, Francis H. Langley

President Resumes Chair

Recognition of Woman's Auxiliary and other guests

Report: Homer L. Pearson Jr., Secretary, State Board of Medical Examiners

Election of one Delegate and one Alternate to A.M.A. House of Delegates for two year terms beginning January 1, 1958

(Terms expiring December 31, 1957—
Delegate, Louis M. Orr; Alternate, Richard A. Mills)
(A.M.A. By-Laws, Chapter IX, Sec. 1: "In order to be eligible for election to membership in the House of Delegates, a physician must have been an Active or Service Member of the American Medical Association for at least two years immediately preceding the session of the House in which he is to serve.")

Reference Committee Personnel announced by President

1. HEALTH AND EDUCATION

Essex Room

Walter C. Payne Sr., *Chairman*
Leo M. Wachtel
C. Frank Chunn
V. Marklin Johnson
Carl S. McLemore

2. PUBLIC POLICY

Park Lane Room

Chas. J. Collins, *Chairman*
S. Carnes Harvard
Burns A. Dobbins Jr.
James T. Cook Jr.
Leffie M. Carlton Jr.

3. FINANCE AND ADMINISTRATION

Spectator Room

Norval M. Marr Sr., *Chairman*
Donald W. Smith
Floyd K. Hurt
James R. Boulware Jr.
Francis T. Holland

4. LEGISLATION AND MISCELLANEOUS

Newcastle Room

L. Washington Dowlen, *Chairman*
Raymond H. King
Melvin M. Simmons
Alpheus T. Kennedy
Jack Q. Cleveland

Presentation of Resolutions and Supplemental Reports
(Resolutions not included in House of Delegates Handbook and supplemental additions to annual reports of chairmen of committees should be typed in duplicate and placed on the Speaker's table immediately after they are presented.)

Reports of Committee Chairmen and Resolutions:

(To Reference Committee No. 1)

Scientific Work, George T. Harrell Jr.
Medical Postgraduate Course, Turner Z. Cason
Cancer Control, Ashbel C. Williams
Venereal Disease Control, C. W. Shackelford
Tuberculosis and Public Health, Phillip W. Horn
Maternal Welfare, E. Frank McCall
Child Health, Warren W. Quillian

(To Reference Committee No. 2)

Conservation of Vision, Charles C. Grace
Medical Education and Hospitals, Walter E. Murphree
Medical Economics, Robert E. Zellner
Representatives to Industrial Council, Chas. L. Farrington
Grievance, David R. Murphey Jr.
Nursing, Jere W. Annis
Blood, Louis E. Pohlman

(To Reference Committee No. 3)

Board of Governors, Francis H. Langley
Necrology, Alvin L. Stebbins
Advisory to Woman's Auxiliary, John P. Ferrell
Councilor Districts and Council, Herschel G. Cole
Advisory to Selective Service for Physicians and Allied Specialists, J. Rocher Chappell
Emergency Medical Service, Rowland E. Wood
Blue Shield Liaison, Henry J. Babers Jr.
Resolution: Blue Shield Service Category—Hillsborough County Medical Association
Resolution: Blue Shield Fee Schedule—Escambia County Medical Society
Reports: Medicare Program, John D. Milton
Medicare Fee Schedule, Donald F. Marion

(To Reference Committee No. 4)

Legislation and Public Policy, H. Phillip Hampton
Mental Health, Sullivan G. Bedell

State Controlled Medical Institutions, William D. Rogers

Poliomyelitis Medical Advisory, Richard G. Skinner Jr.

Resolution: Changes in State Welfare Law—Escambia County Medical Society

Resolution: Workmen's Compensation Fee Schedule—Escambia County Medical Society

Other Business

Announcements

Adjournment

MONDAY

May 6

GENERAL SESSION

HOLLYWOOD BEACH HOTEL — PAGEANT ROOM

9:30 to 11:00 a.m.

Call to Order, Francis H. Langley, President
Invocation, The Reverend S. Harry Russell, West Hollywood Methodist Church, Hollywood
Address of Welcome, Walter J. Glenn Jr., Fort Lauderdale, President, Broward County Medical Association
Introduction—Fraternal Delegates from other states and other eminent guests
Announcements
Address, "National Socio-Economic Issues Confronting Medicine," Ernest B. Howard, Assistant Secretary, American Medical Association, Chicago
Address, "Management of Hemorrhagic Diseases," Lemuel W. Diggs, Director of the Department of Medical Laboratories for the University of Tennessee and City of Memphis Hospitals, Memphis

11:00 to 11:30 a.m.

Recess to visit the Technical and Scientific Exhibits

11:30 to 12:30 p.m.

Address, "Progress in Cancer Control," J. R. Heller, Director, National Cancer Institute, Bethesda, Md.
Address, "Diuresis and Antidiuresis," Thomas Findley, Research Professor of Medicine for Cardiovascular Diseases, Medical College of Georgia, Augusta

12:30 to 2:00 p.m.

Luncheons

Alumni, Fraternity, Specialty Societies

THETA KAPPA PSI

12:30 p.m. Luncheon
All attending must register with the young lady at a marked table in the lobby.

DUKE MEDICAL ALUMNI
REGENCY ROOM

1:00 p.m. Luncheon
Speaker: Wiley Forbus, Professor of Pathology Duke University School of Medicine, Durham, N. C.

2:00 to 4:00 p.m.

Meetings

Reference Committees
No. 1 Health and Education—Essex Room
No. 2 Public Policy—Park Lane Room
No. 3 Finance and Administration—Spectator Room
No. 4 Legislation and Miscellaneous—Newcastle Room

2:00 to 3:00 p.m.

Television

Closed circuit television program, hotel theatre, Robert J. Needles, St. Petersburg, moderator

3:00 to 4:00 p.m.

Recess to visit the Technical and Scientific Exhibits

4:00 to 5:00 p.m.

Blue Shield

Blue Shield Annual Meeting, Pageant Room

7:30 p.m.

Scientific Film Program, hotel theatre

7:30 "Technique of Free Tendon Graft in the Hand," Cabell Young Jr., M.D.
8:00 "The Medical Witness," American Medical Association
8:30 "Cancer Detection," American Cancer Society
9:15 "Pancreatico-duodenectomy," James A. McLeod, M.D.
9:35 "Resection of Abdominal Aortic Aneurysms," Francis N. Cooke, M.D.
10:00 "The Differential Diagnosis of Uterine Bleeding," American Cancer Society
10:50 "Urinary Infections-Etiology, Diagnosis and Treatment," Grayson Carroll, M.D.
11:20 "The Metabolic Insufficiency Syndrome: Diagnosis and Treatment," Smith, Kline & French
11:50 "The Psychologic Aspects of Cancer," American Cancer Society

FLORIDA MEDICAL COMMITTEE FOR BETTER GOVERNMENT

8:00 a.m. Breakfast

HOLLYWOOD BEACH HOTEL—MAIN DINING ROOM

W. Tracy Haverfield, State Chairman ..... Miami
Charles F. Henley, Treasurer ..... Jacksonville
Mrs. Ann Stover, Secretary ..... Miami

Annual Meeting and Election of Officers

FLORIDA TULANE MEDICAL ALUMNI

HOLLYWOOD BEACH HOTEL

6:00 p.m. Cocktail Party
All attending must register with the young lady at a marked table in the lobby.

The 84 technical exhibits in the Mayfair Room are an important part of the Eighty-Third Annual Convention. Please spend some time there as an expression of your appreciation to the firms that are exhibiting. The room is open Monday and Tuesday, 8:30 to 5:30, and Wednesday, 8:30 to 12:30 p.m.

TUESDAY

May 7

SCIENTIFIC ASSEMBLIES

Hollywood Beach Hotel — Pageant Room

Committee on Scientific Work: George T. Harrell Jr., Chairman, Gainesville; Charles McD. Harris Jr., West Palm Beach; Arthur J. Butt, Pensacola; Donald F. Marion, Miami, and Richard Reeser Jr., St. Petersburg.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the Secretary when read.

"No address or paper before the Association, except those of the president and orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any subject."

FIRST SCIENTIFIC ASSEMBLY

9:30 a.m. "Toxoplasmosis, Congenital and Acquired; Ocular Manifestations," Sherman B. Forbes, Tampa.
Discussion: Kenneth S. Whitmer, Miami
James N. Patterson, Tampa

9:55 a.m. "Hazards in the Management of Peptic Ulcer with Anticholinergic Drugs: A Reemphasis," Hyman J. Roberts, West Palm Beach.
Discussion: Winston K. Shorey, Miami.

10:20 a.m. "Diffuse Idiopathic Pulmonary Fibrosis," Augustus E. Anderson Jr., Jacksonville, and G. Leonard Emmel, Gainesville.
Discussion: Jack Reiss, Miami.

10:45 a.m. Recess to visit exhibits.

11:00 - 12:30 p.m. Panel on Cardiovascular Surgery, Moderator: Thomas Findley, Research Professor of Medicine for Cardiovascular Diseases, Medical College of Georgia, Augusta.

"Surgical and Physiologic Consideration in the Development of an Artificial Heart-Lung for Clinical Use," Robert S. Litwak, Miami.

"Value of Combined Heart Catherization in the Selection of Patients for Valvular Heart Surgery," Philip Samet, Miami Beach

SECOND SCIENTIFIC ASSEMBLY

2:00 p.m. "Transplantation of the Ureters into an Isolated Ileal Loop," J. Harold Newman, Jacksonville

2:25 p.m. "Reconstructive Arterial Surgery," James D. Moody, Orlando
Discussion: Francis N. Cooke, Miami.

2:50 p.m. "Facial Fractures, Their Recognition and Management," Bernard L.N. Morgan, Jacksonville.
Discussion: Clifford C. Snyder, Miami
Joseph E. O'Malley, Orlando

3:15 p.m. Recess to visit exhibits.

3:30 - 5:00 p.m. Panel on Cancer, Moderator: J. R. Heller, Director, National Cancer Institute, Bethesda, Md.

"Incidence of Skin Cancer Arising from Precancerous Dermatoses," Wesley W. Wilson, Tampa.

"Sarcoma Botryoides," Howard C. Duckett, Jacksonville.

"New Technics in the Study of Carcinoma of the Uterine Cervix," Sam W. Denham, Jacksonville.

PATIO PARTY

Hollywood Beach Hotel — Pool

Tuesday, 6:00 p.m.

Tickets for the Patio Party will be on sale at the Registration Desk. Informal entertainment appropriate to the occasion is being arranged by the local committee.

CONFERENCE OF COUNTY MEDICAL SOCIETY PRESIDENTS AND SECRETARIES

Hollywood Beach Hotel—-Main Dining Room

8:00 a.m. — Breakfast

William C. Roberts, President-Elect, Florida Medical Association, presiding.

WEDNESDAY

May 8

Second Meeting House of Delegates

Wednesday, 9:00 a.m.

Hollywood Beach Hotel — Pageant Room

Delegates sign official attendance cards at 9:00 a.m. at the table of Credentials Committee, Louis M. Orr, Chairman, Ralph W. Jack and Walter H. Winchester, located at the entrance to the Pageant Room.
No Alternates are to be seated for Delegates attending Sunday's meeting.

President Langley in the Chair, 9:30 a.m.

Number of eligible Delegates present. Report by Louis M. Orr, Chairman, Credentials Committee.

Recommendations of Reference Committees:

No. 1. Health and Education
Walter C. Payne Sr., Chairman

No. 2. Public Policy
Chas. J. Collins, Chairman

No. 3. Finance and Administration
Norval M. Marr Sr., Chairman

No. 4. Legislation and Miscellaneous
L. Washington Dowlen, Chairman

Report: Representative to Student A.M.A. Convention

Presentation of Life Certificates

Other unfinished business

Election of Association Officers, 12:00 noon

President-elect

First Vice President

Second Vice President

Third Vice President

Secretary-Treasurer

Editor of The Journal

Dr. William C. Roberts escorted to the Chair as new President

Presentation of Personal Gavel to Dr. Roberts

Presentation of Past President's Button and Certificate of Honor to Dr. Francis H. Langley by Dr. William C. Roberts, President

Adjournment

BOARD OF PAST PRESIDENTS

8:00 a.m. Breakfast

HOLLYWOOD BEACH HOTEL — MAIN DINING ROOM

Edward Jelks, *Chairman*

John D. Milton, *Secretary*

Election of a Chairman and Secretary
(According to precedence, Leigh F. Robinson will succeed the present chairman and Francis H. Langley the present secretary.)

TECHNICAL EXHIBITS

Technical exhibits will be located in the Mayfair Room of the Hollywood Beach Hotel. They have a real scientific value, and physicians who wish to keep abreast of the times and be familiar with the latest development in drugs and medical appliances should spend some time with these exhibits; a surprising amount of useful information can be procured in this way.

Many exhibitors make no attempt to sell, the representatives of the firms being there primarily to give the latest information regarding their products. Those who have items for sale will gladly give information whether there is a purchase or not. Be sure to register your name with the various representatives who are exhibiting. The following firms have arranged for exhibits at the Hollywood meeting:

Exhibitor	Booth
Abbott Laboratories	59
A. S. Aloe Company	20
American Ferment Co., Inc.	62
Ames Company, Inc.	86
Anderson Surgical Supply Company	34
Atlantic Surgical Supply Co., Inc.	37
Audio-Digest Foundation	46
Ayerst Laboratories	77
Bilhuber-Knoll Corporation	73
The Borden Company	11
Brayten Pharmaceutical Company	42
Burroughs Wellcome & Company	84
Chicago Pharmacal Company	71
Ciba Pharmaceutical Products, Inc.	32
The Coca-Cola Company	80
Continental X-Ray Corp. & Standard X-Ray Co.	39
Dictaphone Corporation	18
The Doho Chemical Corporation	74
Dome Chemicals, Inc.	13
Drug Specialties, Inc.	45
Eaton Laboratories	78
Eisele and Company	50
Encyclopaedia Britannica, Inc.	93
C. B. Fleet Company, Inc.	81
Florida Brace Corporation	65
Florida Physicians Supply	27
Geigy Pharmaceuticals	92
General Electric Co., X-Ray Dept.	55
Gray Pharmaceutical Co., Inc.	66
Guild of Prescription Opticians of Florida	29
J. E. Hanger, Inc.	63
Hart Drug Corporation	91
Charles C. Haskell & Co., Inc	68
Hoffmann-LaRoche, Inc.	79
Ives-Cameron Company	44
Keleket X-Ray of Florida	22
Kremers-Urban Company	69
Lederle Laboratories Division	61
Eli Lilly & Company	48
R. J. Lindquist Company	15
Lloyd Brothers, Inc.	26
J. A. Majors Company	58
Maltbie Laboratories Division	67
Mead Johnson & Company	49
Medical Supply Company	53
Medical Supply Company of Jacksonville	41
Merck Sharp & Dohme, Inc.	82
The Wm. S. Merrell Company	52
The National Drug Company	87
Nepera Chemical Company, Inc.	70
Organon, Inc.	90
Ortho Pharmaceutical Corporation	31
Parco Surgical Supplies	64
Parke, Davis & Company	23
Pet Milk Company	19
Pfizer Laboratories	85
Picker X-Ray Corporation	14
Pitman-Moore Company	51
Wm. P. Poythress & Co., Inc.	28
The Purdue Frederick Company	72
R. J. Reynolds Tobacco Company	94
Riker Laboratories	89
Ritter Company, Inc.	75-76
A. H. Robins Company, Inc.	36
J. B. Roerig and Company	38
Ross Laboratories	47
Sanborn Company	10
Sandoz Pharmaceuticals	60
Schering Corporation	30
Julius Schmid, Inc.	16
G. D. Searle & Company	25
Sherman Laboratories	83
Smith, Kline & French Laboratories	17
E. R. Squibb & Sons	88
Surgical Equipment Company	56
Surgical Supply Company	24
Tablerock Laboratories	33
Taylor Laboratories	12
The Upjohn Company	54
VanPelt & Brown, Inc.	40
Walker Laboratories	21
Warner-Chilcott Laboratories	57
Westwood Pharmaceuticals	43
White Laboratories, Inc.	35

SCIENTIFIC EXHIBITS

Hollywood Beach Hotel

Ground Floor Arcade

Immunize Against Poliomyelitis, National Foundation for Infantile Paralysis

Muscular Dystrophy Medical Display, Muscular Dystrophy Association

Prescalene Biopsy, Richard G. Connar, M.D., and Leffie M. Carlton Jr., M.D., Tampa

Blood Vessel Bank, Francis N. Cooke, M.D.; Thomas Starzl, M.D., and the University of Miami School of Medicine

Benign Tumors of the Stomach and Duodenum, George P. Daurelle, M.D., Miami

Medical Postgraduate Meetings, Committee on Medical Postgraduate Course, Florida Medical Association

Relation of Nutrition to Dental Health, Florida Dietetic Association

Pediatric Harelip Correction, David R. Millard Jr., Miami

Long Term Anticoagulant Therapy in Coronary Atherosclerosis, E. Sterling Nichol, M.D.; William C. Phillips, M.D., and Gus G. Casten, M.D, Miami

A Tumor Registry, American Cancer Society

Surgical Diseases of the Esophagus, Hawley H. Seiler, M.D., Tampa

Comparative Anatomy of Human and Animal Skulls Pertaining to the Olfactory System, Philip Weinstein, M.D., Miami

Important Points in Prescribing Cataract Glasses—A Utropian Cataract Lens, Robert C. Welsh, M.D., Miami

Incidence of Skin Cancer Arising from Precancerous Dermatoses, Wesley W. Wilson, M.D., Tampa

Skin Bank (Its Contribution to Burn Therapy), Thomas J. Zaydon, Coconut Grove

Artificial Heart-Lung for Open Heart Surgery, Department of Surgery, University of Miami School of Medicine

Potential Pitfalls with Pentothal, Department of Anesthesiology, University of Miami School of Medicine

University of Florida Health Center — An Integrated University Approach, University of Florida College of Medicine

Stapes Mobilization and/or Fenestration—Experience in 850 Cases, J. Brown Farrior, M.D., Tampa

Bureau of Professional Relations, College of Pharmacy, University of Florida, Gainesville,

Lobby

Florida Medical Association

Dade County Medical Association

Blue Shield of Florida

THIRTIETH ANNUAL MEETING

WOMAN'S AUXILIARY TO THE FLORIDA MEDICAL ASSOCIATION

CONVENTION COMMITTEE CHAIRMEN

Chairman and Co-Chairman	Mrs. James M. Weaver Mrs. James F. Berry
Meeting Committee	Mrs. Floyd A. Osterman
Decoration Committee	Mrs. Francis D. Pierce
Transportation Committee	Mrs. John R. Hege Jr.
Exhibit Committee	Mrs. Harry C. Jelstrom
Golf Tournament Committee	Mrs. Paul W. Hughes
Favors Committee	Mrs. William K. Peck
Publicity Committee	Mrs. Norris M. Beasley
Distinguished Guests Committee	Mrs. Thomas L. Roberts Jr.
Registration Committee	Mrs. Burns A. Dobbins Jr.

GENERAL INFORMATION

GENERAL REGISTRATION will be held along with registration of members of the Florida Medical Association at the Hollywood Beach Hotel, Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., Wednesday, 8:30 a.m. to 12:00 noon.

REGISTRATION FOR DELEGATES for the Annual Auxiliary Session: (Location to be announced.)

AUXILIARY MEETINGS: All meetings of the Auxiliary will be in the Hollywood Beach Hotel.

TICKETS: Annual Auxiliary Luncheon (Location to be announced.)

PATIO PARTY: Tickets may be obtained at the general registration desk.

GOLF TOURNAMENT: Third Golf Tournament for Ladies will be held. See information under General Convention Golf Committee

PROGRAM

Sunday, May 5

2:30 p.m.

Coronet Room

PRE-CONVENTION EXECUTIVE BOARD MEETING:

OUR DISTINGUISHED GUESTS: Mrs. Ralph Flanders, President, Woman's Auxiliary to the American Medical Association.

Mrs. O. W. Robinson, President, Woman's Auxiliary to the Southern Medical Association.

PRESIDING: Mrs. Scottie J. Wilson, Fort Lauderdale, President

Monday, May 6

9:00 a.m.

Coronet Room

OPENING SESSION: Annual meeting, Woman's Auxiliary to the Florida Medical Association, Hollywood Beach Hotel, Cornet Room

CALL TO ORDER: Mrs. Scottie J. Wilson, President

INVOCATION: The Reverend William N. Gardner, Pastor, First Baptist Church of Hollywood

PLEDGE OF LOYALTY: To the Women's Auxiliary to the American Medical Association

I pledge my loyalty and devotion to the Woman's Auxiliary to the American Medical Association. I will support its activities, protect its reputation and ever sustain its high ideals.

ADDRESS OF WELCOME: Mrs. John R. Hege Jr., President, Woman's Auxiliary to the Broward County Medical Association

Mrs. Scottie J. Wilson
President, Woman's Auxiliary

Mrs. Ralph Flanders, President
Woman's Auxiliary to the American Medical Association

RESPONSE: Mrs. James Nixon, President, Woman's Auxiliary to the Bay County Medical Society

A MESSAGE FROM THE ASSOCIATION: Dr. William C. Roberts, President-Elect, Florida Medical Association.

PRESENTATION OF CONVENTION CHAIRMAN: Mrs. James M. Weaver, Fort Lauderdale

ANNOUNCEMENTS

PRESENTATION OF MRS. RALPH FLANDERS, President, Woman's Auxiliary to the American Medical Association

INTRODUCTIONS: Mrs. Scottie J. Wilson, President.

REMARKS FROM OUR ADVISORY BOARD: Dr. John P. Ferrell, St. Petersburg

REMARKS FROM THE WOMAN'S AUXILIARY to the Southern Medical Association: Mrs. O. W. Robinson, President

ROLL CALL AND REPORT ON NUMBER OF ELIGIBLE DELEGATES PRESENT: Mrs. Wendell J. Newcomb, Pensacola

MINUTES OF THE TWENTY-NINTH ANNUAL MEETING: Mrs. Wendell J. Newcomb

CONVENTION RULES OF ORDER: Mrs. Laurance D. Van Tilborg, Ft. Pierce, Parliamentarian

1. *Each county auxiliary will be represented by the president and a delegate for every 25 members or major fraction thereof.*
2. *Officers and delegates are requested to sit in sections provided for them.*
3. *When addressing the Chair, the member shall announce her name and that of her auxiliary*
4. *Resolutions may be considered only when presented by the committee on resolutions after proper processing.*
5. *All visitors are welcome at the general session and are requested to register.*
6. *No one delegate may speak more than twice on any one subject and not for more than two minutes at any one time.*
7. *Oral reports of counties shall be limited to two minutes.*
   a. *Timekeepers shall notify each speaker when time is up.*
   b. *Please hold applause until all reports have been given.*
   c. *Those giving reports please occupy front row of seats until report has been presented.*
8. *Roberts Rules of Order shall apply in all instances not covered by these special rules.*

PRESENTATION OF COMMITTEE CHAIRMEN FOR LOCAL ARRANGEMENTS

IN MEMORIAM

GAVEL TO FIRST VICE PRESIDENT: Mrs. Augustine S. Weekley, Lutz

ADDRESS OF THE PRESIDENT: Mrs. Scottie J. Wilson

COUNTY PRESIDENTS' ORAL PRESENTATION OF AUXILIARY ACHIEVEMENTS, DISTRICTS C AND D:

Broward, Mrs. William K. Peck
Dade, Mrs. Robert F. Dickey
Hillsborough, Mrs. William J. Lancaster
Lee-Charlotte-Collier-Hendry, Mrs. William M. Taylor
Manatee, Mrs. Henry E. Rasmussen-Taxdal
Palm Beach, Mrs. Lorenzo James
Pinellas, Mrs. William D. Futch
Polk, Mrs. John E. Daughtrey
Sarasota, Mrs. Dunlap W. Oleson
St. Lucie-Okeechobee-Martin, Mrs. Henry E. Branca

REPORTS OF STATE OFFICERS AND COMMITTEE CHAIRMEN:

Note: If there is no objection, the reports of state officers and chairmen will be accepted as printed and placed on file, except for such reports that require action of the convention.

UNFINISHED BUSINESS

NEW BUSINESS

ELECTION OF 1958 NOMINATING COMMITTEE

ELECTION OF THE DELEGATES TO THE NATIONAL CONVENTION

REPORTS OF THE COURTESY RESOLUTION COMMITTEE: Mrs. Wilbur C. Sumner, Jacksonville

REPORT OF REGISTRATION: Mrs. James M. Weaver, Fort Lauderdale, Convention Chairman

COUNTY PRESIDENTS' ORAL PRESENTATION OF AUXILIARY ACHIEVEMENTS, DISTRICTS A AND B:
Alachua, Mrs. Glenn O. Summerlin
Bay, Mrs. James D. Nixon Jr.
Brevard, Mrs. James A. Sewell
Duval, Mrs. Wilbur C. Sumner
Escambia, Mrs. Samuel B. D. Rhea
Jackson-Calhoun, Mrs. Henry I. Langston
Lake-Sumter, Mrs. Fred A. Vincenti
Leon - Gadsden - Liberty - Waukulla - Jefferson, Mrs. Thomas J. Bixler
Marion-Levy, Mrs. William J. McGovern
Orange, Mrs. Roger E. Phillips
St. Johns-Flagler, Mrs. James J. DeVito
Seminole, Mrs. Orville L. Barks
Volusia, Mrs. John J. Cheleden

REPORT OF 1957 NOMINATING COMMITTEE: Mrs. Samuel S. Lombardo, Jacksonville, Chairman

ELECTION OF AUXILIARY OFFICERS:
President-Elect
First Vice President
Second Vice President
Third Vice President
Fourth Vice President
Secretary
Treasurer

INSTALLATION OF OFFICERS: Mrs. Ralph Flanders, President, Woman's Auxiliary to the American Medical Association

PRESENTATION OF PAST PRESIDENTS' PIN: To Mrs. Scottie J. Wilson by Mrs. Samuel S. Lombardo

PRESENTATION OF THE GAVEL: To the new President by Mrs. Wilson

INAUGURAL ADDRESS: Mrs. Perry D. Melvin, President

ADJOURNMENT

1:00 p.m. — Regency

ANNUAL AUXILIARY LUNCHEON: Honoring the members of the Florida Medical Association. Guest speaker: Mrs. Ralph Flanders, President, Woman's Auxiliary to the American Medical Association, "Health Is Our Greatest Heritage"

Tuesday, May 7

9:30 a.m. — Coronet

SCHOOL OF INSTRUCTION for state committee chairmen, Board members, county presidents and presidents-elect, and county committee chairmen, Mrs. Perry D. Melvin, President, presiding

12:30 p.m.

POST-CONVENTION BOARD MEETING: Mrs. Melvin, presiding

DUTCH TREAT LUNCHEON

AD HOC COMMITTEE CHAIRMEN

Courtesy Resolutions	Mrs. Wilbur C. Sumner, Jacksonville
Election	Mrs. William D. Futch, St. Petersburg
Memorial	Mrs. Robert F. Dickey, Miami
Reading	Mrs. Samuel B. D. Rhea, Pensacola
Timekeeper	Mrs. Roger E. Phillips, Orlando

The Technical Exhibit

A feature that adds materially to the success of the annual convention is the technical exhibits. Each firm represented features products of particular interest to the physician. Make a special effort to visit each booth at some time during the convention and register your name with the attending representative.

The Technical Exhibit Hall will be open Sunday, Monday and Tuesday, 8:30 a.m. to 5:30 p.m., and on Wednesday from 8:30 a.m. to 12:30 p.m. The booths may be dismantled after 12:30 p.m.

SANBORN COMPANY.—10

THE BORDEN CO. 11

Borden's Prescription Products booth is the place to discuss the latest information on infant feeding. On display is Borden's complete line of infant formula products. You will find the answer to milk allergy in either liquid or powdered MULL-SOY, the pioneer hypoallergenic food. If you are encountering hyperirritability or excoriations, you'll be interested in BREMIL, a complete formula patterned after breast milk. For prematures DRYCO provides a flexible high protein, low fat diet, and don't forget BETA LACTOSE, the ideal milk sugar.

TAYLOR LABORATORIES 12

The Taylor Laboratories will feature an elixir containing a form of iron which can be tolerated by any one (we cordially invite you to place your more refractory patients on M.A.V. at our expense), young or old. The product is known as M. A. V. and Mr. Pat Golden can furnish some very convincing case histories.

DOME CHEMICALS, INC. 13

DOME CHEMICALS, INC., presents the most complete line of antipruritic and anti-inflammatory dermatologicals: DOMEBORO WET DRESSINGS; ACID MANTLE CREME (pH 4.2) and LOTION (pH 4.5); CORT-DOME CREME (pH 4.6) and LOTION (pH 4.6); VLEM-DOME, the modernized pleasant form of VLEMINCKX'S SOLUTION; VI-DOM-A BUCCAL TABS, VI-DOM-A-C ORAL-TABS and VI-DOM-C ORAL-TABS for high vitamin blood levels through buccal absorption; and four specific whole crude coal tars.

PICKER X-RAY CORP. 14

"Dial-the-part" automation distinguishes the new Picker Anatomatic Century II x-ray unit. Simple to use, it eliminates the need for technic charts or manual setting of separate technic factors. The operator merely "dials" the body part, makes a simple thickness-of-part setting, and pushes a button for the exposure. Coupled with this control is a new full size motor-driven table with a single x-ray tube quickly changed over from fluoroscopy to radiography.

R. J. LINDQUIST CO. — 15

JULIUS SCHMID, INC. — 16

An interesting and informative exhibit featuring RAMSES Flexible Cushioned Diaphragm; RAMSES Vaginal Jelly; VAGISEC Jelly and Liquid, two new products embodying "Carlendacide," the recent development of Carl Henry Davis, M.D., and C.G. Grand for vaginal trichomoniasis therapy; and XXXX (FOUREX) Skin Condoms, RAMSES and SHEIK Rubber Condoms for the control of trichomonal re-infection.

SMITH, KLINE & FRENCH LABORATORIES — 17

DICTAPHONE CORP. — 18

For the busy doctor — the Dictaphone Time-Master dictating machine with plastic Dictabelt record. The Time-Master saves time, saves money on case histories, reports, instructions . . . all medical paper work.

For the busy hospital — the Dictaphone Telecord System of network dictation by phone. The Telecord System extends dictating facilities throughout the hospital most economically . . . helps keep medical records complete and accurate.

PET MILK CO. — 19

A. S. ALOE CO. — 20

A cordial welcome is extended to the members of the Florida Medical Association to visit the A. S. Aloe Company exhibit. A unique array of Surgical, Physio-Therapy, X-Ray and Laboratory equipment will be displayed.

WALKER LABORATORIES — 21

KELEKET X-RAY OF FLORIDA — 22

PARKE, DAVIS & CO. — 23

Medical service members of our staff will be in attendance at our exhibit for consultation and discussion of various products. Important specialties, such as Penicillin S-R, Benadryl, Ambodryl, Dilantin Suspension, Vitamins, Eldec, Oxycel, Milontin, Amphedase, Chloromycetin, Thrombin Topical, etc., will be featured. You are cordially invited to visit our exhibit.

SURGICAL SUPPLY CO. — 24

G. D. SEARLE & CO. — 25

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be Nilevar, the new anabolic agent; Rolicton, the new safe, non-mercurial oral diuretic; Vallestril, the new synthetic estrogen with extremely low incidence of side reactions; Banthine and Pro-Banthine, the standards in anti-cholinergic therapy; and Dramamine, for the prevention and treatment of motion sickness and other nauseas.

LLOYD BROTHERS, INC. — 26

FLORIDA PHYSICIANS SUPPLY — 27

WM. P. POYTHRESS & CO., INC. — 28

GUILD OF PRESCRIPTION OPTICIANS OF FLA. — 29

SCHERING CORP. — 30

The Schering exhibit presents the Meti-steroid preparations METIMYD, METI-DERM, METRETON, SIGMAGEN, METICORTEN, and METICORTELONE. Clinical and laboratory data demonstrating the advantages of these new steroids in topical and systemic therapy of allergic and inflammatory diseases are offered.

ORTHO PHARMACEUTICAL CORP. — 31

CIBA PHARMACEUTICAL PRODUCTS, INC. — 32

TABLEROCK LABORATORIES — 33

ANDERSON SURGICAL SUPPLY CO. — 34

Anderson Surgical Supply Co., Tampa and St. Petersburg, assure their usual excellent presentation of the latest medical and surgical items and equipment. Your representative will be happy to greet you and answer questions. Be sure to visit Booth No. 34.

WHITE LABORATORIES, INC. — 35

A. H. ROBINS CO., INC. — 36

The A. H. Robins Co. exhibit is introducing Donnagesic Extentabs, the first extended action codeine tablets, providing 10-12 hour relief of pain on a single dose. Also shown are Ambar Tablets and Extentabs — indicated in control of obesity and elevation of mood; and for peptic ulcer, Robalate — effective antacid now available in palatable, free-flowing liquid form as well as in tablets — and Donnalate — which combines Robalate and the Donnatal formula.

ATLANTIC SURGICAL SUPPLY CO., INC. — 37

J. B. ROERIG AND CO. — 38

CONTINENTAL X-RAY CORP. & STANDARD X-RAY CO. — 39

VANPELT & BROWN, INC. — 40

VanPelt and Brown extend a cordial invitation to visit their exhibit where representatives will be happy to answer questions and supply clinical samples of their products.

MEDICAL SUPPLY CO. OF JACKSONVILLE — 41

We invite you to visit our booth to see the new items which will be featured.

BRAYTEN PHARMACEUTICAL CO. — 42

WESTWOOD PHARMACEUTICALS — 43

FOSTEX CREAM and FOSTEX CAKE are new, easy to use, therapeutically effective cleansing type medications for the treatment of dandruff, acne vulgaris and seborr-

heic dermatitis. They contain Sebulytic*, a unique combination of penetrating anionic soapless cleansers and wetting agents which are highly antiseborrheic, and exert antiseborrheic, and exert antibacterial and keratolytic effects.

*Trademark

IVES-CAMERON CO. — 44

At our exhibit, you will find on display SYNALGOS®, a new analgesic relaxant, MONICHOL®, a practical medication for the normalization of elevated serum cholesterol levels, as well as PERICLOR®, a new chloral hypnotic-sedative. Ask our representatives for information on DUOTINIC®, a nonconstipating hematinic; OXSORBIL®, for the management of fat intolerance dyspepsia; MUCARA®, for the relief of chronic constipation, and other outstanding Ives-Cameron specialties.

DRUG SPECIALTIES, INC. — 45

AUDIO-DIGEST FOUNDATION — 46

Audio-Digest Foundation — a subsidiary of the California Medical Association — gives the busy physician an effortless tour through the best of current medical literature each week. This medical tape-recorded "newscast" — compiled and reviewed by a professional Board of Editors — may be heard in the physician's automobile, home or office. The Foundation also offers medical lectures by nationally-recognized authorities.

ROSS LABORATORIES — 47

ELI LILLY AND CO. — 48

You are cordially invited to visit the Lilly exhibit. The display wil contain information on recent therapeutic developments. Lilly sales people will be in attendance. They welcome your questions about Lilly products.

MEAD JOHNSON & CO. — 49

EISELE AND CO. — 50

PITMAN-MOORE CO. — 51

It is with genuine pleasure that we welcome you personally to the Pitman-Moore booth. Novahistine, for relief of nasal congestion accompanying the common cold, allergic rhinitis, and actue or chronic sinusitis, will be featured.

Neo-Polycin, an antibiotic ointment with the unique Fuzene base, which provides greater release of the antibiotics to the site of infection, will also highlight your interest.

THE WM. S. MERRELL CO. — 52

Merrell representatives will be on hand to discuss TACE, a new distinctive estrogen and Meratran, a new unique antidepressant.

Please stop at our booth, they will be happy to talk with you.

MEDICAL SUPPLY CO. — 53

THE UPJOHN CO. — 54

GENERAL ELECTRIC CO., X-RAY DEPT. — 55

SURGICAL EQUIPMENT CO. — 56

WARNER-CHILCOTT LABORATORIES — 57

J. A. MAJORS CO. — 58

ABBOTT LABORATORIES — 59

SANDOZ PHARMACEUTICALS — 60

SANDOSTEN a new and powerful anti-permeability agent effective in the treatment of itching.

BELLERGAL Space Tabs: assures around the clock control of functional complaints (example- menopause symptoms) in the periphery where they originate.

BELLADENAL Space Tabs: a more effective sustained-action antispasmodic that can be adjusted to the needs of the patient.

CAFERGOT PB: The most effective oral medication for the relief of migraine headache with G. I. disturbance accompanied by tension.

LEDERLE LABORATORIES DIV.,
AMERICAN CYANAMID CO. — 61

AMERICAN FERMENT CO., INC. — 62

J. E. HANGER, INC. — 63

A display of orthopedic and prosthetic appliances emphasizing the latest in materials, methods and construction.

A Hyper Extension Brace suggesting a new principle of applying pressure.

A Plastic Arm complete with Cine-Plasty Transmission and APRL Hand.

Custom Made Orthopedic Shoes with Lasts.

PARCO SURGICAL SUPPLIES — 64

FLORIDA BRACE CORP. — 65

GRAY PHARMACEUTICAL CO., INC. — 66

The Gray Pharmaceutical Company, Inc., exhibit features:

DIOVAC CAPSULES, DIOVAC SYRUP, DIOVAC PEDIATRIC SYRUP. DIOVAC, by reducing the surface tension of water, enables moisture to permeate hard, dry fecal material, softens stools, and permits normal evacuation. DIOVAC is indicated for all degrees of constipation.

LYSIDOX is a protein anabolic for geriatric, convalescent and surgical patients. LYSIDOX increases the biologic value of dietary proteins and improves total protein metabolism.

I-GLUTAVITE is a palatable mixture of therapeutic dosages of monosodium L-Glutamate and niacin with specific vitamins and minerals. It is indicated for elderly patients who suffer from cerebral symptomatology.

DEXAZYME is a somatic stimulant and psychic antidepressant. In depressed patients, DEXAZYME raises mood levels, improves mental clarity, and supports metabolism.

MALTBIE LABORATORIES DIVISION
WALLACE & TIERNAN, INC. — 67

You are cordially invited to visit the Maltbie booth to discuss our products with our representatives. Featured items will be DESENEX, the safest and most effec-

KYNEX is an entirely new, readily soluble, single sulfonamide exhibiting excellent antibacterial action at radically reduced dosage.

KYNEX offers desirable clinical advantages hitherto not obtained by any related drug—

LOW DOSAGE: a total maintenance dose of only 2 tablets daily.

HIGH SOLUBILITY: prompt absorption, adequate diffusion into body fluid and tissue.

PROLONGED ACTION: therapeutic blood levels within the hour, blood concentration peaks within 2 hours—5-10 mg. per cent blood levels persist 24 hours after single oral dose of 1 Gm.

cuts dosage 75%

BROAD-RANGE EFFECTIVENESS: KYNEX is particularly efficient in urinary tract infections due to sulfonamide-sensitive organisms, including E. coli, Aerobacter aerogenes, paracolon bacilli, streptococci, staphylococci, Gram-negative rods, diphtheroids and Gram-positive cocci.

SAFETY: KYNEX offers a margin of clinical safety based on low required dosage, solubility, slow excretion rate. Although KYNEX Sulfamethoxypyridazine is a sulfonamide derivative and the usual precautions regarding such drugs should be observed, the low daily dose of 1.0 Gm. is all that is required for the therapeutic blood levels. No increase in dosage is recommended.

CONVENIENCE: The low dose of 1 Gm. (2 tablets) per day offers optimal convenience and acceptance to patients.

EACH TABLET CONTAINS: sulfamethoxypyridazine 0.5 Gm. (7½ grains). **AVAILABLE:** Bottles of 24 and 100 Tablets.

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tive fungicide; CHOLAN V, for maximal hydrocholeresis with effective spasmolysis; and BIFRAN, for control of obesity and associated biliary disturbance.

CHARLES C. HASKELL & CO., INC. — 68

Representatives will be present to welcome visiting physicians and to answer any inquiries regarding our ethical prescription specialties, such as our BELBARB family (sedative-spasmolytic), HASAMAL — HASACODE (analgesic), IROSUL-C (hematinic with vitamin C), PANTABEEROID (thyroid therapy), and other rational therapeutic combinations.

KREMERS-URBAN CO. — 69

The KREMERS-URBAN booth will feature the most potent visceral antispasmodic LEVSIN SULFATE . . . SALIMEPH-C with its ACTH-like anti-rheumatic activity, but without side effects . . . NITROL Tablets-Ointment for the prevention of anginal attacks and AMITRATE for coronary insufficiency . . . KUTAPRESSIN for the control of capillary bleeding and for rebellious skin diseases . . . MILKINOL 'Improved' the new hydrolipo-philic constipation correctant.

NEPERA CHEMICAL CO., INC. — 70

CHICAGO PHARMACAL CO. — 71

The Chicago Pharmacal Company representative, Mr. Otto Krivan, welcomes your visit to our booth featuring: URISED, nationally-known and clinically proven tablet which provides both comfortable sedation and thorough antisepsis in cystitis; CITRISAN, effective anti-arthritic tablet combining salicylamide, lemon bioflavonoid complex, and Vitamin C; RESYDESS, a safe weight-reducing tablet which keeps the patient free of anxiety and tension; plus a complete line of tablets, injectables, ointments, and liquids awaiting your inspection.

THE PURDUE FREDERICK CO. — 72

The Purdue Frederick Company will feature:

SENOKOT Tablets and Granules — new non-bulk, non-irritating constipation corrective acting selectively on the parasympathetic (Auerbach's) plexus in the large bowel, physiologically stimulating the neuromuscular defecatory reflex.

PRE-MENS — the multidimensional premenstrual tension therapy.

SOMATOVITE — clinically proven to promote weight gain, increase apetite and reduce hyperactivity and restlessness.

SIPPYPLEX — the modern comprehensive therapy for peptic ulcer.

BILHUBER-KNOLL CORP. — 73

Oral METRAZOL is indicated for the aged patient where senile confusion, convalescence or fatigue are present. New information and literature on this therapy is available and your discussion is invited.

Information concerning the use of the anti-asthmatic QUADRINAL, as well as DILAUDID, BROMURAL, TENSODIN, THEOCALCIN and the other Bilhuber chemicals is also available. You are invited to discuss these preparations with our representatives.

DOHO CHEMICAL CORP. — 74

Doho Chemical Corporation is pleased to exhibit:

AURALGAN, Ear medication in Otitis Media and removal of Cerumen;

OTOSMOSAN, Effective, non-toxic Fungicidal and Bactericidal (gram negative-gram positive) in the suppurative and aural dermatomycotic ears;

RHINALGAN, Nasal decongestant free from systemic or circulatory effect and equally safe to use on infants as well as the aged.

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Mallon Chemical Corporation, Subsidiary of the Doho Chemical Corporation, is also featuring:

RECTALGAN, Liquid topical anesthesia, for relief of pain and discomfiture in hemorrhoids, pruritus and perineal suturing.

DERMOPLAST, Aerosol freon propellent spray for fast relief of surface pain, itching, burns and abrasions, Also Obs. & Gyn. use.

RITTER CO., INC. — 75-76

AYERST LABORATORIES — 77

Physicians are invited to visit Booth No. 77 where Ayerst representatives will be on hand to welcome them and discuss any Ayerst specialties of interest to them.

EATON LABORATORIES — 78

HOFFMANN-LAROCHE, INC.—79

THE COCA-COLA CO. — 80

Ice-cold Coca-Cola served through the courtesy and cooperation of the Ft. Lauderdale Coca-Cola Bottling Company and The Coca-Cola Company.

C. B. FLEET CO. — 81

During the past fifty years PHOSPHO-SODA (FLEET) has been a symbol of elegance in sodium phosphate medication. FLEET ENEMA DISPOSABLE UNIT — an enema solution of Phospho-Soda (Fleet) — is a worthy companion product. The single-use unit simplifies and assures satisfying preparation for proctoscopy and as a routine enema it is a boon to the hospitalized patient.

MERCK SHARP & DOHME — 82

SHERMAN LABORATORIES — 83

Severe asthmatic attacks are not merely relieved, but terminated in 10 to 20 minutes by Elixophyllin, given orally. In milder attacks, its speed has been described as "instantaneous."

Vital capacity increases were noted as soon as 5 minutes after administration. Pick up these data and reports on their clinical significance in the management of asthma at the Sherman booth.

BURROUGHS WELLCOME & CO. — 84

The extensive research facilities of 'B. W. & Co.', both here and in other countries, are directed to the development of improved therapeutic agents and techniques.

An informed staff will be at our booth to discuss our products and latest developments.

PFIZER LABORATORIES — 85

(*Continued on page* 1060)

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Research

The importance of research to our economy is obvious in Florida. In very recent years, a major industry was revitalized and transformed by the development of methods for the production of frozen juice concentrates. Further studies made it possible to turn citrus wastes into cattle feed and other valuable by-products. Industry here and elsewhere acknowledges that research pays rich dividends, and it is planned and supported as an essential part of industrial organization.

In the medical and health fields, research has expanded rapidly. Through generous federal support, the National Institutes of Health of the United States Public Health Service have grown into the nation's, and the world's, foremost medical research organization. Its research grants program has increased greatly the research capacity of medical schools and universities. The importance of these developments is acknowledged. There has not, however, been a balanced growth of medical research. The concentration of investigation in research institutes and university departments has placed high emphasis on basic research and experimental laboratory studies. The investigator is separated from the practical problems, and "applied research" receives less attention than warranted. Further, the present trend in the organization of research suggests that this is an activity for the select few. Actually, all physicians need to approach their daily problems with the inquiring mind of an investigator. As in the past, careful observations in the daily work of physicians can lead to the accumulation of valuable new knowledge. Medical research needs to be strengthened at the state and local levels as it has been at the national level. Such problems as the following call for attention:

A recent editorial in the Journal of the American Medical Association (Feb. 16, 1957, p. 551) summarizes the divergent opinions relative to the justification for the continuation of compulsory premarital and prenatal serologic blood testing. Its concluding opinion was: "Careful epidemiologic studies, not assumed theories, are urgently needed to either confirm or refute the value of the compulsory blood test." The knowledge needed can be obtained only by the accumulation of exact observations on individual patients. New therapeutic agents for tuberculosis have decreased the average length of hospitalization. There are differences of opinion as to the advantages and disadvantages of early discharge, with continuing

medication at home. Secure knowledge can be obtained only by complete and prolonged follow-up studies, and these demand the generous cooperation of practitioners. Undoubtedly, there is a similar need for the evaluation of the long range response to tranquilizing drugs on patients with and without hospitalization. There is an increasing interest in the epidemiology of chronic diseases, and such studies must be made in communities, not in research institutes. These are illustrative of the many problems needing investigation which can be carried out only through the cooperation of practitioners.

With timely appreciation of need, the Florida State Board of Health, on recommendation of Dr. Wilson T. Sowder, Health Officer, has established a position of Coordinator of Research, and has designated a Committee on Research. Plans are being evolved looking toward an active program of special studies. The interest and cooperation of practitioners will be essential and may be anticipated.

The industrialist endorses research as sound business. Speaking for medicine, Dr. Irving H. Page, Chairman of the Scientific Council of the American Heart Association, concluded an editorial review of major gains in heart research with the statement: "Support of research is a wise investment in health." (Today's Health, February 1957, p. 13)

Annual Meeting, Hollywood, May 5-8

The Eighty-Third Annual Meeting of the Florida Medical Association will be held in Hollywood, beginning on Sunday, May 5, and continuing through Wednesday morning, May 8. For the eighth time the convention is being held in the Hollywood Beach Hotel, and for the thirteenth time in the Greater Miami area.

The schedule for the convention is somewhat different this year. The first innovation is the holding of the first session of the House of Delegates on Sunday afternoon in the Pageant Room of the hotel from 3 to 5 o'clock. In view of this change, all specialty groups will hold their meetings on Saturday and on Sunday morning and evening. No meetings are to be scheduled for Sunday afternoon which do not terminate by 2:30, the hour at which the registration of delegates to the convention will begin.

Monday morning will be devoted to a general session beginning at 9:30 a.m. Following the opening ceremonies, Dr. Ernest B. Howard, Assistant Secretary of the American Medical Association, will speak on "National Socio-Economic Issues Confronting Medicine." There will follow the address of the President's guest speaker, Dr. Lemuel W. Diggs of Memphis, where he serves on the faculty of the University of Tennessee College of Medicine as Professor of Medicine and Director of the Department of Medical Laboratories for the University of Tennessee and City of Memphis Hospitals. This distinguished clinical pathologist has chosen for his subject "The Management of Hemorrhagic Diseases." Scheduled for the final hour of the morning general session are two scientific papers to be presented by out-of-state speakers.

A closed circuit television five state Videclinic will be a novel feature of the afternoon program on Monday from 2 to 3 o'clock. This special attraction is a panel program sponsored by Smith, Kline & French Laboratories, and viewers may submit questions by telephone to the panel in Chicago. "The Physician and Emotional Disturbance" is the title of the subject matter. The panel members will be Dr. Howard Rome, Psychiatrist, Mayo Clinic; Dr. C. H. Hardin Branch, Psychiatrist, University of Utah; Dr. E. Irving Baumgartner, Secretary, Section on General Practice of the American Medical Association; and Dr. Andrew S. Tomb, Chairman of the Liaison Committee on Mental Health of the American Academy of General Practice. Physicians in four other states, Oklahoma, Louisiana, Kansas and North Carolina, who are holding their annual meetings concurrently, will also have a part in this program.

At 4 p.m., immediately after the television program, the annual meeting of Blue Shield will be held. There will be no conflicting meetings at that hour, and all delegates to the convention are urged to attend since they are active members of Blue Shield.

Alumni, fraternity and specialty group dinners are scheduled for Monday night. At 7:30 p.m. there will be a motion picture program presenting scientific subjects.

Dr. William C. Roberts, President-Elect, will honor the presidents and secretaries of all component county medical societies by entertaining them at breakfast on Tuesday morning at 8.

Dr. Robert J. Needles, of St. Petersburg, who will serve as moderator for Florida in the five state Videclinic being held during the Association's annual meeting.

The two scientific assemblies of the convention will be held on Tuesday. The first scientific session, beginning at 9:30 a.m., will feature three medical papers and a panel on cardiovascular surgery. In the afternoon, from 2 until 5, the program for the second scientific session will consist of three surgical papers and a panel on cancer. Twelve members of the Association and a number of prominent out-of-state physicians will participate in the scientific program.

The patio party is scheduled for 6 p.m. on Tuesday. This year there will be no annual dinner.

The concluding session of the convention will be the second session of the House of Delegates at 9:30 a.m. on Wednesday.

The scientific and technical exhibits will add interest to the occasion as they are particularly good this year. The attractions of the Hollywood Beach Hotel and of the Greater Miami area are too familiar to the Association's members to be extolled here. The frequency with which the Association returns to that area for the annual meetings attests its appeal.

Program

The program for the Eighty-Third Annual Convention of the Florida Medical Association is published in this issue of The Journal beginning on page 1001.

Florida Medical Foundation Established

Having for its purpose the promotion of better medical care in Florida, the Florida Medical Foundation has now been established by the Board of Governors of the Florida Medical Association, as directed by the House of Delegates at the annual meeting of the Association in May 1956. The charter was approved by Circuit Judge Edwin L. Jones of Duval County on Sept. 24, 1956, and the by-laws were adopted by the Board of Directors on Jan. 27, 1957, at a meeting in Jacksonville.

The Foundation is a nonprofit organization, controlled and administered by the Association. As stipulated in the charter, it has for its Board of Directors the Association's Board of Governors. It provides a vehicle through which the Association's members may command leadership in all medical affairs in the state, exclusive of legislative activities.

As set forth in the charter, the nine objectives of the Foundation are:

1. The improvement of the health and medical care of the people of Florida.
2. The fostering and sponsorship of graduate and postgraduate medical education.
3. Financial aid for residents of Florida needing assistance who are pursuing an education in medicine.
4. The promotion of scientific knowledge in medicine among members of the medical profession.
5. The promotion of scientific knowledge in medicine between the medical profession and the public in Florida.
6. The promotion and sponsorship of medical research.
7. Assistance, through charitable acts, to deserving indigent and destitute members of the Florida Medical Association who shall be ill, incapacitated, or superannuated and in great need of aid.
8. The promotion among physicians of Florida of the principles of medical ethics.
9. Assistance to members of the Florida Medical Association, through a welfare defense fund, in defeating charges without merit of professional malpractice.

Contributions to the Foundation may be earmarked for any one of these projects or for any combination of projects, or it may be left to the discretion of the Board of Directors to select the project or projects from those designated in the

charter. Application has been made to the Internal Revenue Service to certify the Foundation as a nonprofit organization exempt from taxation and to allow donors to deduct contributions to it from their income tax.

The Board of Directors welcomes comment from the membership of the Association. Each and every member is urged to send suggestions regarding implementation of the Foundation's program to the Florida Medical Foundation, P. O. Box 2411, Jacksonville 3. A progress report was recently mailed to all members earnestly requesting such a response.

It is the intention of the Board of Directors to solicit donations to the Foundation from Association members prior to seeking donations from other foundations, organizations and the laity.

The present officers and members of the Board of Directors of the Foundation are: President, Dr. Edward Jelks, Jacksonville; Vice President, Dr. John D. Milton, Miami; Secretary-Treasurer, Dr. Clyde O. Anderson, St. Petersburg; and Drs. Herbert L. Bryans, Pensacola; Samuel M. Day, Jacksonville; Meredith Mallory, Orlando; George S. Palmer, Tallahassee; William C. Roberts, Panama City; Reuben B. Chrisman Jr., Coral Gables; Francis H. Langley, St. Petersburg; Duncan T. McEwan, Orlando; and Eugene G. Peek Jr., Ocala.

New York State Journal of Medicine Sesquicentennial Issue

On February 18 to 21 of this year the Medical Society of the State of New York celebrated its Sesquicentennial. As part of the celebration, the issue of Feb. 1, 1957, of the New York State Journal of Medicine was completely devoted to the program of the annual meeting, held at the Hotel Statler in New York City, and to the history of the society. This important medical periodical deserves heartiest congratulations on this largest issue ever published, which appears in a specially designed cover.

Compiling the historical record of a century and a half of medicine in New York State was in itself a monumental task. During those years the society's performance has been most impressive. It was in February of the year 1807 that the founders of this society met in Albany to establish what is today, with its more than 24,000 members, the third largest medical organization of its kind in the world. Faithfully chronicled within the pages of this issue of the New York State Journal of Medicine is the story of the brilliant achievements of this society through the years from the beginning of the nineteenth century to the present time. Every effort was made to illustrate the fascinating accounts by the various contributors with pictures from the society's archives and other sources.

Supplementing this medical chronicle at the Sesquicentennial convention was a public exposition of the history of medicine in the Empire State entitled "Progress in the Art of Medicine from Colonial Times to the Atomic Age." Accenting the romance rather than the science of medicine, this display consisted of nontechnical independent exhibits, tracing the history of various types of medical, health, and ancillary groups throughout the state.

Certainly the official organ of this great state medical society commemorated this historic milestone in medicine's miraculous march of progress in peculiarly fitting fashion. Preserved within the pages of this one issue is the story of 150 years of achievement by the profession of medicine in the Empire State in research, in clinical medicine and surgery, in organization, both internally and relative to the institutions of government, and in the continuous struggle for the advancement of the public health. This noteworthy contribution to the history of medicine could well be emulated by other state medical journals. Such a praiseworthy endeavor would greatly enrich the annals of medicine in this country.

The Journal of the Florida Medical Association extends warmest congratulations to Dr. Laurance D. Redway, Editor, his staff and all the distinguished contributors who made this fine example of constructive medical journalism possible.

Cancer Cytology Congress April 25-29, 1957

Elaborate preparations have been made for the First Pan American Cancer Cytology Congress to be held late this month at the Eden Roc Hotel in Miami Beach. The Department of State of the United States Government transmitted invitations to the Ministers of Health of 21 nations in the Western Hemisphere to send representatives to the Congress. In addition, a "good-will" delegation of civic leaders and prominent business men from the Miami area toured Latin-American countries to publicize the Congress. Stressing its

international importance, they sought active participation and support from these countries and stressed the desirability of having as many Latin visitors as possible.

The Congress is unique, and it will never again be held in Miami. Thus visitors from the Latin-American countries and from this country have an exceptional opportunity to learn the latest advances in the entire field of cancer research and to visit a city that is rapidly becoming a scientific and medical center of international repute. They will go away from this international gathering better equipped to attack the cancer problem from a worldwide viewpoint.

As mentioned in the February issue of The Journal, a comprehensive program presented by authorities of world renown has been arranged, and a large attendance is anticipated. The Congress will convene on April 25 and continue through April 29.

Co-sponsoring the Congress are the Cancer Institute at Miami, the University of Miami, the Southern Society of Cancer Cytology, and the Cancer Cytology Foundation of America, Inc. A grant from the United States Department of Health, Education, and Welfare will make possible simultaneous broadcasting of the proceedings in English and Spanish. Other financial sponsors are the Public Health Foundation for Cancer and Blood Pressure Research, Inc., of New York, and the Williams Foundation of Buenos Aires, Argentina.

Florida Heart Association Annual Meeting Hollywood, May 4, 1957

The Florida Heart Association will hold its annual meeting this year at the Hollywood Beach Hotel in Hollywood on Saturday, May 4, immediately preceding the annual convention of the Florida Medical Association. The annual meeting of the membership will convene at 1 p.m. and will be followed by the medical-scientific program at 1:45 p.m., with adjournment scheduled for 5:45 p.m.

Dr. William P. Hixon, President, of Pensacola, will present the opening address at the medical-scientific session. There will follow six papers on original work, with Dr. Simon D. Doff, of Jacksonville, serving as moderator for this portion of the program. The essayists and their subjects are: "Actue Non-Specific Pericarditis," by Dr. Henry Fuller of the Watson Clinic, Lakeland; "Spectrophotometric and Enzymatic Observations Related to, and Clinical Implications of, Streptococcal M Protein Activity," by Drs. A. A. Hakim and Milton S. Saslaw of the National Children's Cardiac Hospital, Miami; "Lipoprotein Studies on a Thousand Persons Using Gofman's Technique and Remarks About a New Fat Tolerance Test," by Dr. D. E. Beischer of the United States Naval School of Aviation Medicine, Pensacola; "The Use of Fascia Lata in Ligations of Friable Ductus Arteriosus," by Drs. Kenneth A. Morris and Wilbur C. Sumner, Jacksonville; "The Use of Extracorporeal Circulation in Open Heart Surgery: Physiologic and Metabolic Considerations," by Drs. Robert S. Litwak, Frant T. Kurzweg, Rufus K. Broadway, John J. Fomon and John J. Farrell of the Department of Surgery of the University of Miami School of Medicine, Miami; and "Equated Electrocardigraphic Leads in the Three Planes of the Body Based on the Frank Principle: A Preliminary Report," by Dr. N. W. Allebach of the United States Naval School of Aviation Medicine, Pensacola.

The closing portion of the program will be devoted to a panel on "The Heart and the Lesser Circulation" with Dr. Sidney Davidson of Lake Worth as moderator. The panel members are: Dr. N. W. Allebach of the United States Naval School of Aviation Medicine, Pensacola; Dr. Francisco A. Hernandez of the National Children's Cardiac Hospital, Miami; Dr. Arthur Otis, Professor of Physiology at the University of Florida, Gainesville; Dr. Frank Cline Jr., Medical Director of Southwest Florida Tuberculosis Hospital, Tampa; Dr. M. M. Dick, cardiologist at the Veterans Administration Hospital, Coral Gables; and Dr. Philip Samet, Director of the Cardio-Pulmonary Laboratory, Mount Sinai Hospital, Miami Beach.

Graduate Medical Education

Seminar on Hematology June 20-22

A Seminar on Hematology will precede the Annual Graduate Short Course this year. Dr. Steven O. Schwartz, Professor of Hematology at the Chicago Medical School, will be the principal lecturer. Lectures will also be given by prominent hematologists in the state, and the College of Medicine of the University of Florida will cooperate in presenting demonstrations. This course will be held at the Science Building of the College of Medicine of the University of Florida in

Gainesville beginning on Thursday, June 20, and ending at noon on Saturday, June 22. Advance registration is solicited.

Annual Short Course June 24-28

The Twenty-Fifth Annual Graduate Short Course will be held in the Science Building of the College of Medicine at the University of Florida in Gainesville beginning on Monday, June 24, and lasting through Friday, June 28. Final details of the program are being completed and will appear in the May issue of The Journal. As usual, the first three days will be devoted to lectures on Medicine and Pediatrics; five lectures on Laboratory Diagnostic Methods will also be presented by the College of Medicine. Physicians who attend will find the laboratories both interesting and instructive. The last two days will be confined to lectures on Surgery and Gynecology.

The faculty will be of the usual high caliber. Dr. James V. Warren, Professor of Medicine at Duke University School of Medicine in Durham, N. C., will return for the lectures on Medicine and will discuss the following subjects: "Diagnosis and Treatment of Angina Pectoris," "The Management of Congestive Heart Failure," "Digitalis and Quinidine Therapy," "Shortness of Breath," "Differential Diagnosis of Diseases of the Lungs," and "Edema."

A brochure containing information about hotels, motels, transportation facilities and other details will be mailed with the final program to all physicians in the state. Ample accommodations within a short distance of the College of Medicine are available.

Cardiovascular Diseases Seminar Held

The Northeast Florida District Heart Association in conjunction with the Division of Postgraduate Education of the College of Medicine of the University of Florida, the Florida Medical Association and the Florida State Board of Health presented a two and a half day Seminar on Cardiovascular Diseases at the Duval Medical Center in Jacksonville on February 21-23. The lectures from the medical angle were presented by Dr. Paul M. Zoll, Assistant Professor of Medicine at the Harvard Medical School in Boston, and Dr. Samuel P. Martin, Professor of Medicine at the College of Medicine of the University of Florida in Gainesville. Those on surgery were presented by Dr. Eric Lazaro, Instructor in Surgery at the Georgetown University School of Medicine in Washington, D. C., in the absence of Dr. Charles A. Hufnagel, who became acutely ill and was unable to attend at the last moment. The lectures were all of an advanced nature presenting the latest information particularly as it relates to cardiac standstill and resuscitation. The latest medical opinions as the result of practical experiences and research with regard to cardiac surgery were also expressed by the lecturers. A total of 105 physicians attended.

Postgraduate Medical Education Exhibit at Annual Meeting, May 5-8

The Committee on Medical Postgraduate Course of the Florida Medical Association will sponsor an exhibit during the annual meeting of the Association in Hollywood on May 5 to 8. The chief purpose of this exhibit is to present as much information as it is possible to obtain regarding postgraduate medical courses to be presented in Florida and elsewhere in the United States within the next year. Any organization intending to present postgraduate medical education courses during the fiscal year beginning May 1, 1957, and wishing this information included in the exhibit should send all details to the Chairman of this Committee at 1625 Riverside Avenue, Jacksonville 4.

The Responsibilities of the Medical Profession in the Use of X-Rays and Other Ionizing Radiation

Statement by the United Nations Scientific Committee on the Effects of Atomic Radiation

The United Nations General Assembly, being aware of the problems in public health that are created by the development of atomic energy, established a Scientific Committee on the Effects of Atomic Radiation. This Committee has considered that one of its most urgent tasks was to collect as much information as possible on the amount of radiation to which man is exposed today, and on the effects of this radiation. Since it has become evident that radiation due to diagnostic radiology and to radiotherapy constitutes a substantial proportion of the total radiation received by the human race, the Committee considers it desirable to draw attention to information that has been obtained on this subject.

Modern medicine has contributed to the control of many diseases and has substantially prolonged the span of human life. These results have depended in part on the use of radiation in the detection, diagnosis and treatment of disease.

There are, however, few examples of scientific progress that are not attended by some disadvantages, however slight. It is desirable, therefore, to review objectively the possible present or future consequences of increased irradiation of populations which result from these medical applications of radiation.

It is now accepted that the irradiation of human beings, and particularly of their germinal tissues, has certain undesirable effects. While many of the somatic effects of radiation may be reversible, germinal irradiation normally has an irreversible and therefore cumulative effect. Any irradiation of the germinal tissues, however slight, thus involves genetic damage which may be small but is nevertheless real. For somatic effects there may, however, be thresholds for any irreversible effects, although, if so, these thresholds may well be low.

The information so far available indicates that the human race is subjected to natural radiation,[1] as well as to artificial radiation due to its medical applications, to atomic industry and its effluents and to the radioactive fall-out from nuclear explosions. The Committee is aware of the potential hazards that such radiation involves, and it is collecting and examining information on these subjects.

The amount of radiation received by the population for medical purposes is now, in certain countries, the main source of artificial radiation and is probably about equal to that from all natural sources. Moreover, since it is given on medical advice, the medical profession exercises responsibility in its use.

The Committee appreciates fully the importance and value of the correct medical use of radiation, both in the diagnosis of a large number of conditions, in the treatment of many such diseases as cancer, in the early mass detection of conditions such as pulmonary tuberculosis, and in the extension of medical knowledge.

Moreover, it appreciates fully the contribution of the radiological profession, through the International Commission on Radiological Protection[2] in recommending maximum permissible levels of of irradiation. As regards those whose occupation exposes them to radiation, the establishment of these levels depends on the view that there are doses which, according to present knowledge, do not cause any appreciable body injury in the irradiation. As regards those whose occupation tion that the number of people concerned is sufficiently small for the genetic repercussions upon the population as a whole to be slight. Whenever exposure of the whole population is involved, however, it is considered prudent to limit the dose of radiation received by germinal tissue from all artificial sources to an amount of the order of that received from the natural background radiation.

It appears most important, therefore, that medical irradiations of any form should be restricted to those which are of value and importance, either in investigation or in treatment, so that the irradiation of the population may be minimized without any impairment of the efficient medical use of radiation.

The Committee is consequently anxious to receive information through appropriate governmental channels as to the methods and the extent by which such economy in the medical use of radiation can be achieved, both by avoiding examinations which are not clearly indicated and by decreasing the exposure to radiation during examinations, particularly if the gonads or the fetus during pregnancy lies in the direct beam of radiation. It seeks, in particular, to obtain information as to the reduction in radiation of the population which might be achieved by improvements in instrument design, by fuller training of personnel, by local shielding of the gonads, by choosing appropriately between radiography and fluoroscopy, and by better administrative arrangements to avoid any necessary repetition of identical examinations.

The Committee also seeks the cooperation of the medical profession to make possible an estimate of the total radiation received by the germinal tissue of the population before and during the child-bearing age. It considers it to be essential that standardized methods of measurement, of types at present available, should be widely used to obtain this information and it emphasizes the value of adequate records, maintained by those using radiation medically, by the dental profession, and by the responsible organizations in allowing such radiation exposure to be evaluated. The Committee is convinced that information of this type will make it possible to decrease the total medical irradiation of the population while preserving and increasing the true value of the medical uses of radiation.

1. The radiation due to natural sources has been estimated to cause between 70 and 170 millirem of irradiation to the gonads per annum in most parts of certain countries in which it has been studied, although higher values are found locally in some areas. See the reports "The Hazards to Man of Nuclear and Allied Radiations" published by the United Kingdom Medical Research Council in June 1956, in which also the millirem is defined; and from information submitted to the Committee.

2. See the report of the International Commission on Radiological Protection (published in the British Journal of Radiology, Supp. 6, December 1954, and in the *Journal français d'electro-radiologie,* No. 10, October 1955, and revised in 1956).

STATE BOARD OF HEALTH

Free Salk Vaccine Available Only for Persons Under Twenty

Physicians in Florida are again urged to make clear to the public and their patients that poliomyelitis vaccine being distributed through health departments is available only for persons under 20 years of age or expectant mothers. This policy applies to public vaccine given in health department clinics as well as to that distributed through the health department to private physicians.

There are two major reasons for this policy. A large supply of the vaccine currently distributed in the state through health departments has been purchased with federal money. Federal law limits this vaccine to persons under 20 years of age or expectant mothers. As this vaccine is used up, it will be replaced with vaccine purchased through state funds. The Florida legislature designated that this vaccine was to be used for children and expectant mothers.

Since some exercise of discretion was granted by the legislature to the Florida State Board of Health in determining eligibility for this vaccine, the question has arisen as to whether this vaccine should be made available to adults of the low income group through age 40. There remain in Florida, however, enough unvaccinated persons under 20 to more than use up the amount of vaccine available under the $550,000 appropriation by the last legislature for purchase of Salk vaccine. Since these are the most susceptible persons, it was decided that existing funds should be used to complete the immunization of this age group before considering the use of public funds for immunization of adults. Every effort, however, should be made to encourage the vaccination of persons up to 40 years of age even though the vaccine for those persons over 20 will have to be purchased from private sources.

CALIFORNIA CAREER OPPORTUNITIES FOR PHYSICIANS AND PSYCHIATRISTS. Employment available as a result of interview *only. Interviews at the APA Conference May 13-17 in Chicago and in such other locations as New York, Boston, St. Louis, Philadelphia, and Minneapolis during May and June.* Assignments in State hospitals, juvenile and adult correctional facilities, or a veterans home. Three salary groups: $10,860-12,000; $11,400-12,600; $12,600-13,800. Citizenship, possession of, or eligibility for California license required. Write Medical Recruitment Unit, Box A, State Personnel Board, 801 Capitol Avenue, Sacramento 14, California.

Medical Officers Returned

Dr. Harry Fagan Jr., who entered military service on August 14, 1954, was released from active duty on August 14, 1956, with the rank of lieutenant, U. S. Navy. His address is 2017 Clark Ave., Raleigh, N. C.

Dr. Richard M. Irwin, who entered military service on August 30, 1954, was released from active duty on August 6, 1956, with the rank of commander, U. S. Navy. His address is 901 S. Flagler Drive, West Palm Beach.

OTHERS ARE SAYING

Write: Don't Phone!

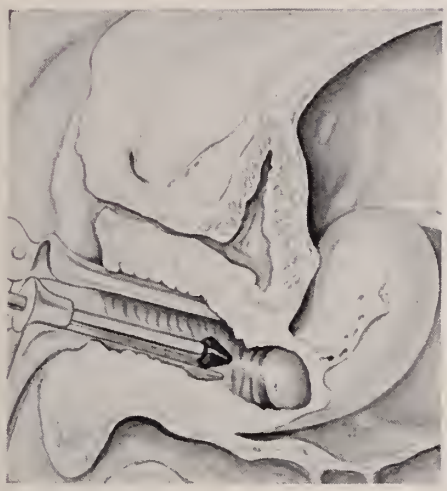
Office hours are hours of hard work — up and down, room to room, person to person, and no two people or responsibilities alike. Have you ever been interrupted and disturbed by a totally unnecessary 'phone call which broke your train of thought, caused you to excuse yourself from a patient, and took time which you could ill-afford to spare? Your secretary can ordinarily intercede on your behalf — unless the caller is a colleague, in which case no questions are asked and you are called to the 'phone.

Let us make a plea for support of Uncle Sam's postoffice instead of the telephone company in routine acknowledgements of referrals and business which do not require personal discussion. A short note which can be read at leisure — if any — or at least when reading one's mail is far more appropriate. Some physicians like to place a consultant's opinion, in writing, in the patient's file; all appreciate the courtesy of a short note.

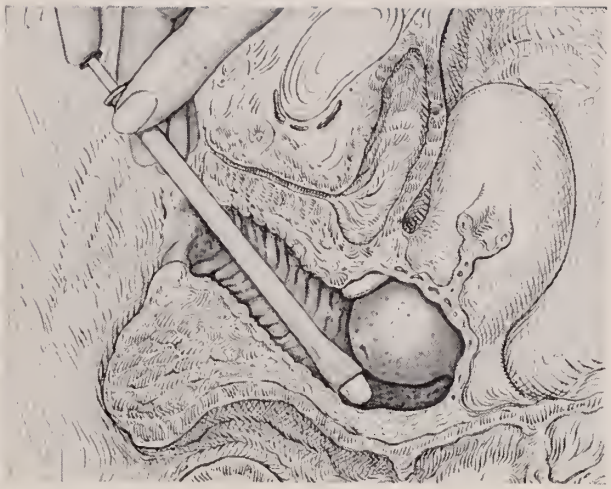
Another point about telephone communication: who should do the waiting while the called party is being located? Most of us might say the other fellow, of course! But let's be reasonable and courteous. The doctor placing the call is doing so at his convenience; the colleague on the receiving end is being interrupted, his thoughts disturbed, probably not at his convenience. If you value his friendship, don't make him do the waiting; keep your seat and be there when he answers.

—*Rocky Mountain Medical Journal*
September 1955

COMPREHENSIVE VAGINITIS REGIMEN



Powder Insufflation



Tablet Insertion

Floraquin® Rebuilds the Defense Mechanism in Vaginitis

Combined office and home treatment with Floraquin provides a comprehensive regimen which encourages restoration of the normal "acid barrier" to pathogenic infection.

Vaginal secretions normally show a high degree of protective acidity (pH 3.8 to 4.4). When this "acid barrier" is disturbed, growth of benign Döderlein bacilli is inhibited and that of pathogens encouraged. Floraquin not only provides an effective protozoacide and fungicide (Diodoquin®) destructive to pathogenic trichomonads and yeast, but also furnishes sugar and boric acid for reestablishment of the normal vaginal acidity and regrowth of the normal protective flora.

Suggested Office Floraquin Insufflation

". . . the vagina is treated daily by swabbing with green soap and water, drying and insufflation of Floraquin powder."*

Suggested Home Floraquin Treatment

"The patient is also issued a prescription for Floraquin vaginal suppositories which she is instructed to insert high into the vagina each evening. On the morning following each application of these suppositories, the patient should take a vinegar water douche. . . ."*

A Floraquin applicator is supplied with each box of 50 Floraquin tablets. G.D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

*Williamson, P.: Trichomonad Infestation, M. Times *84*:929 (Sept.) 1956.

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EVERY WOMAN

WHO SUFFERS

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RADIOLOGIST: Desires association with Radiologist on salary basis, partnership or hospital appointment. Fifty years. Extensive experience in diagnosis, therapy, radium, isotopes. Several publications. Florida license. Write 69-216, P. O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER WANTED: To take over practice of doctor leaving for residency on or before June 1. Central east coast town, population 10,000. For further details write 69-217, P. O. Box 2411, Jacksonville, Fla.

WANTED: Physician interested in Internal Medicine or General Practice. We have an established clinic in the Miami area. Will consider on basis of either salary or percentage. Write 69-219, P. O. Box 2411, Jacksonville, Fla.

CLINIC MANAGER: Position desired as manager of group clinic. Experience: auditing and hospital. Education: B. S. (Business Administration) and M.S. (Hospital Administration). Write 69-218, P.O. Box 2411, Jacksonville, Fla.

GENERAL PRACTICE RESIDENT AVAILABLE: July 1957. Married, age 31. No military obligations. Wishes to find location to practice with group or solo. Interested in all phases, including obstetrics and surgery. Graduate of University of Pennsylvania. Florida license. For further information write to Thomas V. McKee, M.D., 4207 Walnut Street, Philadelphia 4, Pa.

INTERNIST: With 4 years practice. Board certified. 32 years old. Florida license. Licensed to use radioisotopes, seeks consultation or hospital type of practice. Not interested in "family type" house call practice. Protestant, married, Southerner. Write 69-220, P. O. Box 2411, Jacksonville, Fla.

UROLOGIST: Board eligible. Age 32. Four year University residency followed by four years Urologic practice. Army obligation completed. Licensed in Florida. Desires location for practice or association with group or individual. Available immediately. Write 69-221, P. O. Box 2411, Jacksonville, Fla.

PATHOLOGIST WANTED: Opening June 1st. Board or eligibility required. Accredited hospital. 155 beds increasing to 350. Large staff. Pathologist directs laboratori s. Florida license required. Contact Administrator, Morrell Memorial Hospital, Lakeland, Florida.

WANTED: Physician with Florida license. Interest in Physical Medicine and Geriatrics. State qualifications in writing. The Miami-Battle Creek, Miami Springs, Fla.

GENERAL PRACTITIONER: in South Florida desires assistant. Good hospital privileges. Favorable percentage arrangement with guaranteed minimum income. Must be male, graduate of grade A United States or Canadian school. Willing and able to do full general practice. Write 69-215, P. O. Box 2411, Jacksonville, Fla.

INTERNIST OR GENERAL PRACTITIONER: Excellent opportunity to take over good practice in Fort Lauderdale. Contact immediately. Write 69-213, P.O. Box 2411, Jacksonville, Fla.

designed to **control anxiety**

in Arthritis, Asthma, Allergic Dermatoses

with **lower corticoid dosage**

the original tranquilizer-corticoid

Ataraxoid*

prednisolone and hydroxyzine

provides the emotional tranquilizer, ATARAX® (hydroxyzine) and the preferred corticoid, STERANE® (prednisolone) • control of emotional factors by tranquilization enhances response to the corticoid for greater clinical improvement • often permits substantial reductions in corticoid dosage, accompanied by reduction of hormonal side effects • confirmed by marked success in 95% of 1095 cases of varied corticoid indications[1]

ATARAXOID *now written as* **Ataraxoid 5.0**

5 mg. prednisolone, 10 mg. hydroxyzine hydrochloride, in green, scored tablets. Bottles of 30 and 100.

and now available as **NEW Ataraxoid 2.5**

2.5 mg. prednisolone, 10 mg. hydroxyzine hydrochloride, in blue, scored tablets. Bottles of 30 and 100.

and **NEW Ataraxoid 1.0**

1.0 mg. prednisolone, 10 mg. hydroxyzine hydrochloride, in orchid, scored tablets. Bottles of 100.

formerly **Ataraxoid**
NOW written **Ataraxoid 5.0**

advantages: (1) greater flexibility of dosage (2) effective tranquilization permits lower corticoid dosage

1. Personal communications

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CLASSIFIED—Continued

PSYCHIATRIST: To associate with Diplomate. Florida license required. Salary first year, partnership thereafter. Write comprehensively in first letter. Jess V. Cohn, M.D., 1938 Harrison Ave., Hollywood, Fla.

WANTED: Specialist in Obstetrics and Gynecology to associate with group in Dade-Broward area. Board man preferred. Write age, training, chronology of medical experience, reference. Write 69-222, P. O. Box 2411, Jacksonville, Fla.

PHYSICIANS WANTED: Immediate opening for two (2) part-time physicians qualified to interpret survey x-rays and standard chest films. Physicians desiring semi-retirement in Florida will be considered. Salary open. Write Wilson T. Sowder, M.D., State Health Officer, Florida State Board of Health, P.O. Box 210, Jacksonville 1, Fla.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Hyman Merlin, of Miami, announce the birth of a son, Steven Norman, on December 27, 1956.

Dr. and Mrs. Matthew E. Morrow Jr., of Jacksonville, announce the birth of a son, John Love, on February 3, 1957.

Dr. and Mrs. Robert M. Mein, of Jacksonville, announce the arrival of a daughter, Martha Eleanor, in their home.

Dr. and Mrs. Edwin E. Sapp, of Jacksonville, announce the birth of a daughter, Mary Cindy, on January 26, 1957.

Deaths — Other Doctors

Gaillard, Milton T., Baldwin, N. Y.	October 9, 1956
Pafford, Jefferson W., Jacksonville	February 28, 1957
Wright, Eugene Pierson, N. Miami Beach	December 3, 1956

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Bell, William R., Pensacola
Birely, Beverly R., Fort Lauderdale
Brown, Alfred G. Jr., Inverness
Carter, William E., DeLand
Collins, Herbert W., Orlando
Farrar, Edward L. Jr., Orlando
Floyd, Marian A., Winter Park
Greenhouse, Jerome M., Hollywood
Heath, Gordon R., Lakeland
Kelly, James E., Stuart
McNicholas, Anthony J., Pompano Beach
Miller, Malcolm E., Fort Lauderdale
Rogers, David R., Fort Lauderdale
Saltzman, Edward J., Hollywood
Whitcomb, John H., Pensacola
Young, Lloyd U., Fort Pierce

Free the anemic
FROM
IRON INTOLERANCE

℞ FERGON®
BRAND OF FERROUS GLUCONATE

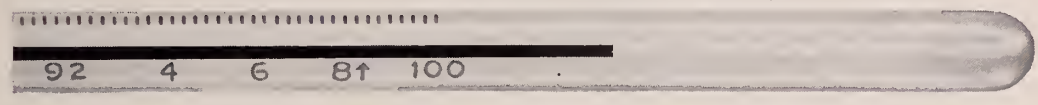
high hemoglobin response
excellent tolerance

FOR ALL SIMPLE IRON DEFICIENCY ANEMIAS

SUPPLIED: Fergon tablets of 5 grains, bottles of 100 and 500.
Fergon tablets of 2½ grains, bottles of 100.
Fergon elixir 6% (5 grains per teaspoonful), bottles of 16 fl. oz.

Winthrop LABORATORIES
NEW YORK 18, N. Y.

can you read this thermometer,



doctor?

Naturally not. Missing calibration makes it worthless.

Equally useless and dangerous is a "quantitative" urine-sugar test that does not quantitate dependably, or omits readings in the critical range.

Enzyme urine-sugar tests are sensitive and specific for glucose—excellent "yes" or "no" tests but undependable for quantitation. King and Hainline,[1] after testing 1,000 urines, found an enzymatic urine-sugar test unable to distinguish in the important range between ½ per cent and 2 per cent or more of urinary glucose. Leonards,[2] in a report on 4,020 tests, revealed that "...in 502 out of 804 tests the wrong interpretation was made." He concluded that enzymatic urine-sugar testing "...as a quantitative procedure is unsatisfactory and can lead to serious error in the interpretation of a patient's clinical condition."[2]

Failure to recognize this limitation of enzyme tests may result in incorrect insulin dosage,[2] and may lead to diabetic complications.

(1) King, J. W., and Hainline, A., Jr.: Commercial Glucose Oxidase Preparations for the Detection of Glucose in Urine, Cleveland Clin. Quart. **23**:212, 1956. (2) Leonards, J. R.: Evaluation of Enzyme Tests for Urinary Glucose, J.A.M.A. **163**:260 (Jan. 26) 1957.

reliable readings throughout the critical range—
does not omit ¾% (++) and 1% (+++)

color
calibrated
CLINITEST®
BRAND

a 15 year "standard" in urine-sugar testing

AMES COMPANY, INC • ELKHART, INDIANA • Ames Company of Canada, Ltd., Toronto

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Recent Advances

In Feeding Prematures

Recent metabolic studies have established rational feeding procedures for prematures.

The initial feeding, 12 hours after birth, consists of one dram of 5 per cent dextrose. This solution is increased by one dram at 2-hour intervals if tolerated and retained.

After twenty-four hours, breast milk or formula (table below) gradually replaces the prelacteal feeding at 2-hour intervals. The volume of a feeding may be increased up to 2 drams daily until maintenance caloric requirements are fulfilled by the fifth day. If the infant shows signs of intolerance, the formula increase is made more slowly and the fluid requirement fulfilled parenterally.

Successful feeding mixtures consist of dilutions of powdered half-skimmed or evaporated whole cow's milk, skimmed or whole lactic acid milk. These formulas contain high protein, moderate carbohydrate and low fat, yielding about 120 calories and 150 cc. fluid per kgm. body weight.

The problems of prematures are always the same but the solutions differ with each era. Today the moderate carbohydrate requirement for normal infants as well as prematures is fulfilled by KARO® Syrup as adequately as a generation ago. Whatever the type of milk adapted to the infant, KARO may be added confidently because it is a balanced mixture of lower sugars resistant to fermentation, non-laxative, easily assimilated and well tolerated by all infants.

Readily available in all food stores.

MEDICAL DIVISION
CORN PRODUCTS REFINING CO.
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℞ FIRST FORMULAS FOR PREMATURES

Fresh or whole lactic acid milk	6 oz.
Water	12 oz.
KARO	1 oz.
Evaporated milk	3 oz.
Water	15 oz.
KARO	1 oz.
Dried milk (half-skimmed)	4 tbsp.
Water	18 oz.
KARO	1 oz.

Feedings: 1½ oz. x 12 x 2 hours

Measures: 1 oz. KARO = 2 tablespoons

Caloric values: KARO, 120 per oz.; Cow's milk, 20 per oz.; Evaporated milk, 45 per oz.; Dried milk (½ skimmed), 35 per oz. (Vol.).

Equivalents: Red Label KARO or Blue Label KARO may be used interchangeably in all formulas.

Adapted from Nelson's Pediatrics, Saunders, Phila. 1954

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Behind Every Bottle . . . A Generation of World Literature

relaxes both mind and muscle

for anxiety and tension in everyday practice

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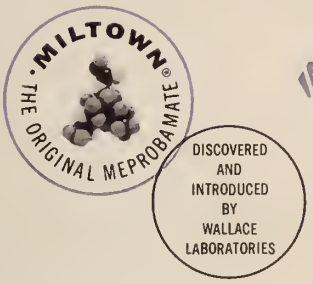
- well suited for prolonged therapy
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to phenothiazine compounds and rauwolfia derivatives
- orally effective within 30 minutes for a period of 6 hours

For treatment of **anxiety and tension states and muscle spasm**

Miltown®

2-methyl-2-n-propyl-1,3-propanediol dicarbamate—U.S. Patent 2,724,720



Tranquilizer with muscle-relaxant action

WALLACE LABORATORIES
New Brunswick, N. J.

SUPPLIED: *400 mg. scored tablets (Bottles of 50 tablets)*
Usual Dosage: 1 or 2 tablets t.i.d.

Literature and samples available on request

CM-3421-R3

nonaddictive

relatively nontoxic

well tolerated

For Anxiety and Tension in Everyday Practice

1 "Habituation does not follow the use of Miltown and . . . withdrawal symptoms have been completely absent."
Pennington, V.M.: J.A.M.A. In press, 1957.

2 "We found meprobamate ['Miltown'] to be a drug of extremely low toxicity and well tolerated . . . no tendency to addiction was encountered."
Altschul, A. and Billow, B.: New York State J. Med. In press, 1957.

3 "No patient developed a tolerance to the drug, although medication was prolonged in some cases as long as six months."
Gillette, H. E.: Internat. Rec. Med. **169**: *453, 1956.*

4 "Complications associated with long-term therapy are probably seen in lowest incidence with meprobamate ['Miltown']."
Fazekas, J. F., Shea, J. G. and Sullivan, P. D.: GP **14**: *75, 1956*

5 "Thus far, there has been very little evidence of actual habituation to meprobamate ['Miltown']. No real tolerance has been observed."
Borrus, J. C.: Med. Clinics of North America. In press, 1957.

Miltown® THE ORIGINAL MEPROBAMATE

THE MILTON® MEPROBAMATE MOLECULE

2-methyl-2-n-propyl-1,3-propanediol dicarbamate—U.S. Patent 2,724,720

Tranquilizer with muscle-relaxant action

DISCOVERED AND INTRODUCED BY WALLACE LABORATORIES, *New Brunswick, N. J.*

SUPPLIED: *400 mg. scored tablets (Bottles of 50 tablets)*
Usual Dosage: 1 or 2 tablets t.i.d.

Literature and samples available on request

NICOZOL
for senile psychoses

From
CONFUSION

NICOZOL relieves mental confusion and deterioration, mild memory defects and abnormal behavior patterns in the aged.

NICOZOL therapy will enable your senile patients to live fuller, more useful lives. Rehabilitation from public and private institutions may be accomplished for your mildly confused patients by treatment with the Nicozol formula. [1 2]

NICOZOL is supplied in capsule and elixir forms. Each capsule or ½ teaspoonful contains:

Pentylenetetrazol . . 100 mg.
Nicotinic Acid . . . . . 50 mg.

1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954

to a
NORMAL
BEHAVIOR
PATTERN

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DRUG SPECIALTIES, INC.
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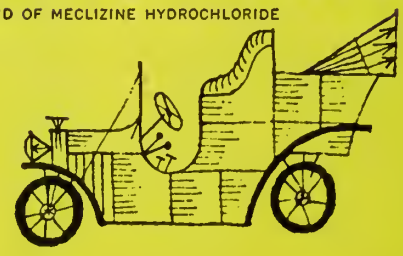
for professional samples of **NICOZOL** capsules and literature on **NICOZOL** for senile psychoses.

Pfizer

longest acting
motion-sickness
preventive

BONAMINE*

BRAND OF MECLIZINE HYDROCHLORIDE



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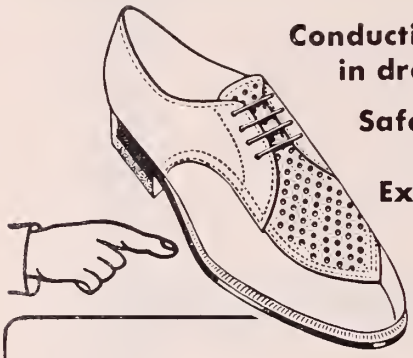

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in dress style

Safety from
Fire and
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- Insole extension and wedge at inner corner of heel where support is most needed.
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★ Conductive Shoes for surgical and operating room personnel. N.B.F.U. specifications.

- We are also the manufacturer of the Gear-Action Shoe designed by noted orthopedic surgeon.
- We make more shoes for polio, club feet and disabled feet than any other shoe manufacturer.

Send for free booklet, "The Preservation of the Function of the Foot Balancing and Synchronizing the Shoe with the Foot."

Write for details or contact your local **FOOT-SO-PORT** *Shoe Agency. Refer to your Classified Directory*

Foot-so-Port Shoe Company, Oconomowoc, Wis.
A Division of Musebeck Shoe Company

STATE NEWS ITEMS

Dr. Samuel E. Kaplan of Venice served as official delegate of the Florida Medical Association to the Seventh Annual Southern Conference on Gerontology held at the University of Florida in Gainesville the middle of March. The two day program centered on the topic "Services for the Aging and the Aged" and was divided into three parts: Services in the Institution, Services in the Home, and Community Services Outside the Home.

Dr. Chas. J. Collins of Orlando has been elected president-elect of the South Atlantic Association of Obstetricians and Gynecologists to take office at the next meeting scheduled at Hollywood, Fla., Feb. 1-5, 1958. Dr. Collins was chosen at the meeting held recently at Charleston, S.C.

The Seventh Annual Postgraduate Medical Seminar sponsored by Mount Sinai Hospital of Greater Miami will be held May 16-19 in the Fontainebleau Hotel at Miami Beach.

The Seminar will emphasize "Recent Advances in the Field of Diabetes, Antibiotics and Geriatrics." Among the faculty scheduled to date are Dr. C. Walton Lillehei, Dr. Ignacio Chavez, Dr. Edward J. Stieglitz, Dr. Garfield G. Duncan, Dr. John H. Garlock, Dr. Monroe J. Romansky, Dr. I. S. Wechsler and Dr. Stephen Rothman.

Members of the American Association of General Practice who attend will be given 24 hours of Group I accreditation.

Dr. Warren E. Wheeler of the Department of Pediatrics, Children's Hospital, Columbus, Ohio, will deliver a special lecture on the "Practicability of Laboratory Micro-Methods for Pediatric Patients" at a meeting being held at 8:00 p.m., April 29, at the Variety Children's Hospital, Miami. An invitation has been extended to all physicians to attend.

Two new full time courses on the management of chronic kidney disease and of hypertension are to be given by the New York University Postgraduate Medical School June 24-27. The first course, management of chronic kidney disease under the direction of Dr. Lawrence G. Wesson, is scheduled for June 24-25. The management of hypertension under the direction of Dr. J. Marion Bryant follows on June 26-27. Further information may be obtained from Office of the Associate

nonspecific diarrheas yield to **CLAFANONE** *...usually in 24 hours*

Clafanone

CLAFANONE is a new, propiophenone compound with marked activity against intestinal coliform organisms and virtually no toxicity or side effects because—being insoluble—its activity is confined to the intestine.

CLAFANONE promptly controls simple diarrheas such as "vacation diarrhea," diarrhea due to dietary indiscretion, and other diarrheas without culturable pathogens. In infectious diarrheas, Clafanone is a useful adjunct to antibacterial and supportive therapy.

Especially acceptable to children as a pleasantly flavored oral suspension. Effective in patients of all ages as a suspension or in tablets.

CLAFANONE™—*brand of alkofanone*

ROCHE *Original Research in Medicine and Chemistry*

Support Medical Education Week, April 21-27 — Keep America Healthy

Dean, New York University Postgraduate Medical School, 550 First Avenue, New York 16, N.Y.

Dr. John C. Ajac of Miami was guest speaker on the Cancer Educational Program for Nurses held recently at West Palm Beach under auspices of the American Cancer Society's Palm Beach County Unit. Dr. Ajac's address concerned Cobalt Therapy: the history of cobalt and the advantages of cobalt therapy in treatment of cancer.

Beta Xi Chapter of Phi Beta Pi at the University of Miami School of Medicine has announced establishment of the Leonard G. Rowntree Lectureship. The first lecture was delivered by Dr. Waltman Walters, Chief of the Surgical Division of Mayo Clinic.

Dr. Jimmy F. Henry of Stuart has been awarded the Distinguished Service Award and named "Man of the Year" by the Junior Chamber of Commerce of Stuart. Dr. Henry is a former mayor of the city.

Dr. J. Basil Hall of Tavares was principal speaker at a recent meeting of the Rotary Club of Leesburg. Dr. Hall's topic was "Does Cigarette Smoking Actually Lengthen Your Life?"

Dr. Myron L. Habegger of Rockledge has returned from Mexico City where he attended the annual meeting of the International College of Physicians.

The World Congress of Gastroenterology has been scheduled for Washington, D. C., May 25-31, 1958, according to announcement by Dr. H. M. Pollard, secretary-general, Ann Arbor, Mich. The Congress is being sponsored by the International Society of Gastroenterology and the host organization in the United States is the American Gastroenterological Association. Information regarding the Congress may be obtained from Dr. Pollard, University Hospital, Ann Arbor.

Dr. George W. Lawson of Miami has been awarded a plaque by the Miami Lions Club in recognition for his activities in the Club's children's program.

Dr. Lawrence C. Manni of Tallahassee was principal speaker at a recent meeting of the Florida A and M University Clinical Association held at Tallahassee.

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A GOOD REPUTATION

It takes years to build, but can be quickly destroyed.
It must be carefully guarded.
"A good name is rather to be chosen than great riches."

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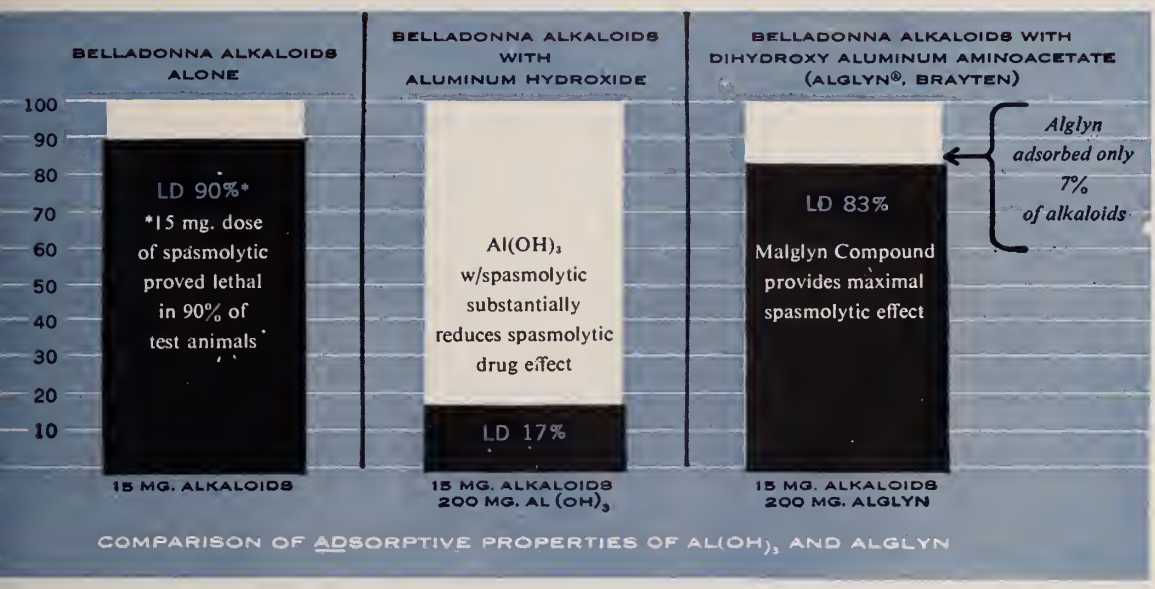
Malglyn® COMPOUND

(dihydroxy aluminum aminoacetate with belladonna alkaloids and phenobarbital)

no wonder . . .

It's no wonder that of the many antacid-spasmolytic formulations promoted to the medical profession, so many physicians have found Malglyn the most consistent in clinical effectiveness.

Here's a startling adsorption story involving simultaneous administration of antacid and spasmolytic drugs!



The above laboratory study clearly indicates that the antacid Alglyn, contained in the Malglyn formula, does not materially interfere with the therapeutic effectiveness of its contained belladonna alkaloids. On the other hand, the marked *ad*sorptive properties of aluminum hydroxide renders its combination with belladonna alkaloids both uneconomical and therapeutically unreliable.

For both rapid and prolonged antacid effect, with consistently effective spasmolytic and sedative action, rely upon Malglyn for treatment of peptic ulcer and epigastric distress.

each tablet contains

dihydroxy aluminum aminoacetate, N.N.R.	0.5 GMs.
belladonna alkaloids (as sulfates)	0.162 MG.
phenobarbital	16.2 MG.

Also supplied: Alglyn® (dihydroxy aluminum aminoacetate, N.N.R. 0.5 Gm per tablet). Belglyn® (dihydroxy aluminum aminoacetate, N.N.R., 0.5 Gm. and belladonna alkaloids, 0.162 mg. per tablet).

Specialities for the Medical Profession only

BRAYTEN PHARMACEUTICAL COMPANY

CHATTANOOGA 9, TENNESSEE

The 1957 meeting of the American Goiter Association will be held May 28-30 in the Hotel Statler, New York City. The program for the meeting consists of papers and discussions dealing with the physiology and diseases of the thyroid gland.

Dr. Herbert W. Virgin Jr. of Miami announces the removal of his office to the Thirteen Thirty-Three Building, 1333 South Miami Ave., Miami.

Dr. Clyde E. Miller Jr. of Pensacola has been appointed assistant county medical director for Escambia county.

Dr. B. Bowman Guerin of Vero Beach has been presented a plaque by the Exchange Club of that city in recognition of his selection to membership in the American College of Surgeons. The presentation was preceded by a talk by Dr. Kip G. Kelso.

Florida physicians presenting papers at the annual meeting of the Florida Trudeau Society being held April 5-6 at the San Juan Hotel, Orlando, are Drs. Turner Z. Cason and Albert V. Hardy, Jacksonville; Drs. Jack Reiss, DeWitt C. Daughtry and Myron Segal, Miami; Dr. Benjamin L. Brock, Orlando; Dr. Frank Cline Jr., Tampa; Drs. Samuel P. Martin and Emanuel Suter, Gainesville; Dr. Hyman J. Roberts, West Palm Beach, and Dr. Charles H. Lasley, Clearwater.

Among the out-of-state speakers are Dr. Martin M. Cummings, Washington, D. C., and Drs. J. S. Robinson and Ray Corpe, Rome, Ga.

Dr. Simon D. Doff, Jacksonville, president of the Society, will preside at the sessions on April 5, and Dr. Howard M. DuBose, Lakeland, vice president, at the sessions on April 6.

Dr. Theodore F. Hahn Jr. of DeLand has returned from Mexico City where he took part in a workshop presented by the National Cardiology Institute.

Dr. Edwin H. Andrews of Gainesville was among the group of Florida physicians who attended the meeting of the American College of Surgeons held recently at San Juan, Puerto Rico.

Dr. James N. Patterson of Tampa will be in Washington, D. C., April 4-6 where as a member

(Continued on page 1046)

who coughed?

WHENEVER COUGH THERAPY IS INDICATED

Hycodan®

(Dihydrocodeinone with Homatropine Methylbromide)

■ Relieves cough quickly and thoroughly ■ Effect lasts six hours and longer, permitting a comfortable night's sleep ■ Controls useless cough without impairing expectoration ■ rarely causes constipation ■ And pleasant to take

Syrup and oral tablets. Each teaspoonful or tablet of HYCODAN* contains 5 mg. dihydrocodeinone bitartrate and 1.5 mg. Mesopin.† Average adult dose: One teaspoonful or tablet after meals and at bedtime. May be habit-forming. Available on your prescription.

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ENDO LABORATORIES
Richmond Hill 18, New York

*U. S. PAT. 2,630,400 † BRAND OF HOMATROPINE METHYLBROMIDE

SIX MONTHS AGO, when Tom came down with tuberculosis, his friends feared that he would disappear from the world of the well to spend *years* in a hospital.

Those fears might have been justified some time ago. Now, fortunately, when cases like Tom's are discovered early, doctors can often restore good health without the long stay in a hospital, and all the attendant worries about the problems of finances, family and future.

Tuberculosis is still a great problem when diagnosis is delayed and the disease has progressed. But experts agree that medical science has surely gained the upper hand . . . through earlier detection, improved surgery and the anti-tuberculosis drugs. These advances have reduced tuberculosis from first to sixth place among the ten leading causes of death.

Obviously, the job is far from ended. Hospitals, universities and research laboratories the world over are searching constantly for more effective medicines of potential value in treating this once-deadly disease.

As a maker of medicines prescribed by physicians, Parke-Davis is proud to be among those engaged in this great, world-wide fight against tuberculosis.

Copyright 1957—Parke, Davis & Company, Detroit 32, Michigan

PARKE, DAVIS & COMPANY

MAKERS OF MEDICINES SINCE 1866

Working with your physician, your pharmacist and your hospital to make modern medical care one of the most rewarding investments of your life.

"Tom" had tuberculosis. And in this latest Parke-Davis message on the cost of medical care, "Tom's case" is used as a specific example of the heartening progress being made against sickness and disease.

The ad points out that, thanks to earlier detection, improved surgery and the anti-tuberculosis drugs, tuberculosis has fallen from first to sixth place among the ten leading causes of death.

Unfortunately, most people do not appreciate the priceless value of today's more effective medical care until they come face to face with a dread disease—like "Tom". And that's why, with a colorful new series of advertisements,* Parke-Davis is helping to give your patients a new and clearer understanding of what modern medical care can do for them—in terms of getting them well quicker, back on the job again, and even saving their lives.

In short, we're continuing to tell your patients that prompt and proper medical care may well turn out to be the biggest bargain ever to come their way.

PARKE, DAVIS & COMPANY

Detroit 32, Michigan

Now in eye-catching color in LIFE, TIME, SATURDAY EVENING POST *and* TODAY'S HEALTH.

TIME * LIFE * TODAY'S HEALTH * POST

Mom "wears
the pants"
once too
often

frozen shoulder

Bursitis and tenosynovitis are new terms to homemakers, but they are not uncommon sequels to overexertion. Early antirheumatic therapy is to be encouraged in the treatment of these conditions, as it is in more serious rheumatic conditions, to alleviate pain and prevent progression of the disorder. With adequate therapy the prognosis of bursitis in its acute stage is good. Delaying therapy may result in extension of the inflammation and gross anatomical changes that tend to incapacitate the patient.

SIGMAGEN provides doubly protective corticoid-salicylate therapy—a combination of METICORTEN® (prednisone) and acetylsalicylic acid providing additive antirheumatic benefits as well as rapid analgesic effect. These benefits are supported by aluminum hydroxide to counteract excess gastric acidity and by ascorbic acid, the vitamin closely linked to adrenocortical function, to help meet the increased need for this vitamin during stress situations.

protective corticoid-salicylate therapy

SIGMAGEN*

corticoid-analgesic compound Tablets

for patients who go beyond their physical capacity

Schering

*T.M. 60-J-217

(Continued from page 1040)

of the Board he will assist in examinations being given there by the American Board of Pathology at the George Washington University School of Medicine. On April 7, Dr. Patterson will be in Boston for the organizational meeting of American hematologists.

COMPONENT SOCIETY NOTES

Dade

Dr. Kermit H. Gates, executive director of Jackson Memorial Hospital, Miami, was principal speaker at the March meeting of the Dade County Medical Association. Dr. Gates presented a progress report on the proposed Jackson Memorial Hospital expansion.

Duval

Mr. Nelson J. Young, head of Professional Management, Detroit, Mich., was principal speaker for the March meeting of the Duval County Medical Society. The title of his address was "Problems in Practice Management."

Hillsborough

Dr. W. H. Muller, Professor and Chairman, Department of Surgery, University of Virginia, was the principal speaker at the March meeting of the Hillsborough County Medical Association. The title of his address was "Recent Advances in Surgery for Cardiovascular Disease."

Indian River

The Indian River County Medical Society has paid 100 per cent of its state dues for 1957.

Lake

The Lake County Medical Society held its February meeting at the Mount Dora Yacht Club with 90 per cent of the membership present.

Principal speaker was Dr. Peter B. Wright, of Orlando, who presented an informative and practical address on orthopedic problems.

During its business session, the Society voted unanimously to give polio vaccine without charge in seven strategically located clinics in the county during February and March.

KELEKET

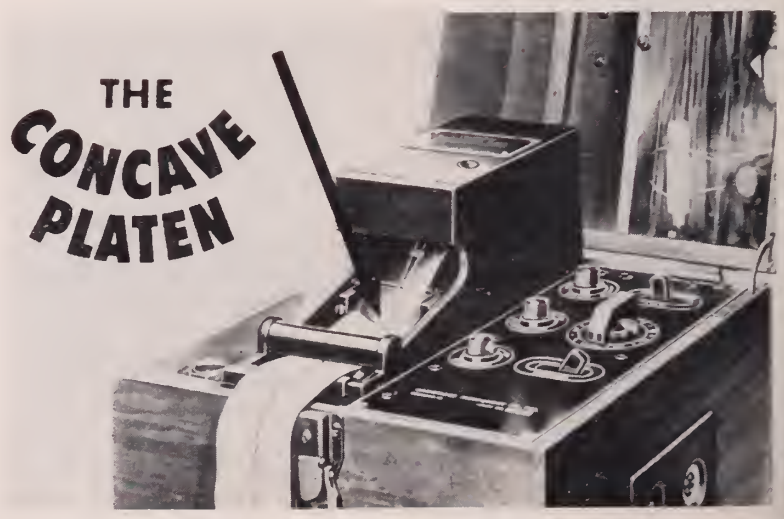
Keleket X-Ray of Florida
HANS B. HEETHER, Owner
Sales and Service

X-Ray Equipment & Supplies—Cambridge Electrocardiograph—Electro-Medical Equipment

The concave platen of the Cambridge direct writing ECG assures more accurate records, providing rectangular coordinates.

— LOCAL SERVICE —
Over 600 units in operation in Florida since 1927.

General Office:
511 N.E. 15th Street
Miami



Branches: West Palm Beach - Tampa - Orlando - Jacksonville

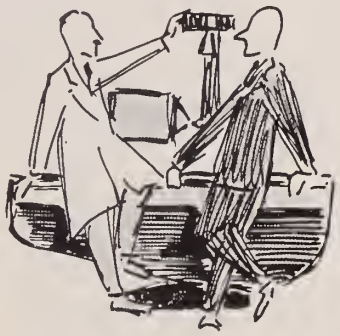
If you could visit with a user of the Picker Anatomatic Century x-ray unit you'd soon know why this remarkable "new way in x-ray" machine has come so far so fast.

He'd probably tell you first how incredibly easy it is to use (just dial the body part and set its thickness... then press the button). He might sigh with relief at having no charts to consult, no calculations to make (the anatomatic principle does all the tedious "figgerin" for you).

He'd probably show you how good a radiograph he gets every time

He might even touch on the peace-of-mind that comes of having a local Picker office so near, with a trained Picker expert always on call for help and counsel

and there'd be no mistaking the light in his eye when it falls on the handsome big-name unit whose fine appearance adds so much to the impressiveness of his office.



P.S. Somewhere along the line the matter of price would come up ... he'd most likely comment on how little he paid to get so much. Or he might even be among those who rent their x-ray machine (Picker has an attractive rental plan, you know).

P.P.S. Next best thing is to call your local Picker man in and let him tell you about this great new machine (find him in your 'phone book) or write Picker X-Ray Corporation, 25 South Broadway, White Plains, N. Y.

MIAMI 35, FLA., 1363 Coral Way
Jacksonville 7, Fla., 1023 Mary Street
St. Petersburg, Fla., 601 Rutledge Bldg.
Orlando, Fla., 1711 Oakmont Street
W. Palm Beach, Fla., 305 South Flagler Drive

Wonderfully Simple. . .

Simply Wonderful!

Baker's Modified Milk is a complete infant food, easy to prescribe and prepare in hospital and home.

Available in liquid and powder forms, both are made *exclusively* from Grade A Milk (U.S.P.H.S. Milk Code). Both contain all requirements for *complete* infant nutrition.

Baker's Liquid — generally preferred for its greater ease of preparation.

Baker's Powder — particularly adaptable for feeding prematures and for use as complemental and supplemental feedings.

Both forms are extremely low in price, costing less than a penny per ounce of formula.

Furnished to hospitals without charge, of course.

Feeding Directions

BAKER'S MODIFIED MILK (Liquid)

NEWBORN INFANTS (Hospital)—1 part Baker's to 2 parts cool water.

FIRST WEEK AT HOME — 1 part Baker's to 1½ parts cool water.

AFTER FIRST WEEK AT HOME — 1 part Baker's to 1 part cool water.

Liquid Powder

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES, INC.

Milk Products Exclusively for the Medical Profession

***Main Office:* Cleveland 3, Ohio • *Plant:* East Troy, Wisconsin**

Pasco-Hernando-Citrus

The Pasco-Hernando-Citrus County Medical Society has paid 100 per cent of its state dues for 1957.

Taylor

The Taylor County Medical Society has paid 100 per cent of its state dues for 1957.

Volusia

Dr. Robert D. Higgins, who has resigned as health director of Volusia county following 15 years' service, was honored at a recent meeting of the Volusia County Medical Society.

Dr. Higgins was presented a plaque and a letter of merit by Dr. Arthur Schwartz, president. He was cited for "his integrity, his cooperative spirit and his outstanding achievements in the field of public health."

St. Johns

Dr. Arthur C. DeGraff, Professor of Therapeutics at New York University College of Medicine, addressed the February meeting of the St. Johns County Medical Society on the subject of concepts of heart disease.

Other visitors at the meeting included Dr. Russell Oppenheimer, former Dean and Professor of Medicine at Emory University College of Medicine, and Drs. Roy M. Baker and Samuel M. Wells, of Jacksonville.

OBITUARIES

Leon M. Thurston

Dr. Leon M. Thurston died at his home in Gulfport on Dec. 24, 1956, after a long illness. He was 92 years of age.

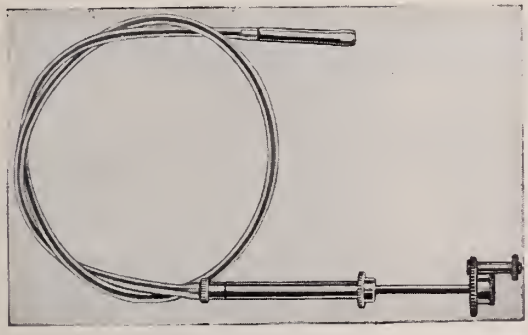
Dr. Thurston was born in 1864. He received his medical education in Pennsylvania and was graduated in 1896 from the Hahnemann Medical College and Hospital of Philadelphia. For 40 years thereafter he engaged in the practice of medicine in Pittsburgh, Pa.

Twenty years ago, Dr. Thurston came to Florida and located in Gulfport. He continued to practice there until last spring, when illness forced him to retire.

Dr. Thurston was licensed to practice medicine in Florida in 1931. He had been a member of the Pinellas County Medical Society since soon after coming to Gulfport to reside. For 19 years he had been a member of the Florida Medical Association, and for many years he held membership in the American Medical Association.

Surviving are the widow, Mrs. Alice E. Thurs-

(Continued on page 1054)



B-2230 Ayre Rotating Stomach Brush, complete, with Brush Tips retracted

Brush Tips extended

Ayre ROTATING STOMACH and COLON BRUSHES

Pat. No. 2,739,585

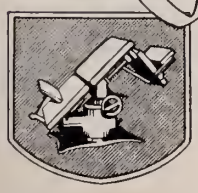
The Ayre Rotating Brushes provide a simple, quick, and efficient method of cancer detection when the disease is still in an early enough stage for effective and successful treatment. In addition, it provides material for diagnostic study to determine whether known ulcers or lesions are benign or malignant.

Safe to use — easy to insert

- Minimum of patient preparation, trauma, or discomfort. Rotation of Brush not painful
- Fast — specimen can be collected in a few minutes

AMERICAN SURGICAL TRADE ASSOCIATION A.S.T.A.

Surgical SUPPLY COMPANY



1050 W. Adams St. P. O. Box 2580 Jacksonville, Fla.

T. B. SLADE, JR. J. BEATTY WILLIAMS

portrait of a contented baby

fibrefree HYPOALLERGENIC FORMULA

1. *An ideal food for milk allergies, eczema and problem feeding*
2. *An excellent formula for regular infant feeding*

Strikingly similar to mother's milk in composition and ease of assimilation, babies thrive on SOYALAC.

Clinical data furnish evidence of SOYALAC'S value in promoting growth and development.

Protein of high biologic value is obtained from the soybean by an exclusive process.

SOYALAC is an ideal "regular" formula. It also helps solve the feeding problems of prematures and infants requiring milk-free diets.

No mixing problem with SOYALAC Concentrated Liquid. Simply dilute with equal amount of water.

FREE BOOKLET AND SAMPLES

A request on your professional letterhead or prescription form will bring complete information and a supply of samples. Address Loma Linda Food Company, Arlington, California or Mount Vernon, Ohio.

LOMA LINDA FOOD COMPANY
ARLINGTON, CALIF. MOUNT VERNON, OHIO

Medical Products Division

BEFORE
Reddened, fissured and excoriated perianal skin, and whitening of the anal folds, accompanied by intense burning and itching of 3 years' duration.

A new therapeutic approach with inherent safety in PRURITUS ANI

HYDROLAMINS®

TOPICAL AMINO ACID THERAPY

AFTER
Same case after treatment with Hydrolamins. Note healing of the inflamed, fissured and excoriated areas and of the whitened anal folds.

Unique physiologic barrier—topical amino acids—brings rapid relief (98%[1]) and complete healing (88%[1])

"...the objectives of therapy in pruritus ani can be listed under 3 headings:

(1) relieve itching: [Hydrolamins produced immediate relief of intractable itching in 98% of patients. The antipruritic effect of one application lasts about twenty-four hours.[1]]

(2) accelerate healing, [Hydrolamins rapidly and completely healed reddened, fissured, macerated and ridged perianal lesions in 88% of cases.[1]]

(3) allow natural healing without trauma due to physical, chemical, allergic, or microbiologic agents."[2] [The amino acids of Hydrolamins promote safe, natural healing while the ointment protects the perianal area from irritation.[1]]

Due to the rapidity of action of Hydrolamins, it is believed that protein-precipitating irritants, responsible for the pruritus, are neutralized. Hydrolamins also forms a biochemical barrier against further irritation.

SUPPLIED: In 1 oz. and 2.5 oz. tubes.

Lewal *Pharmaceutical Company*, *Chicago 14, Illinois*

1. Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, Am. J. Digest. Dis. 18:59 (Feb.) 1951.
2. Fromer, J.L.. Dermatologic Concepts and Management of Pruritus Ani, Am. J. Surg. 90:805 (Nov.) 1955.

children are often this eager...

Because Rubraton tastes so good, most children actually look forward to taking it. What better way could there be for providing these essential nutrients?

Rubraton is indicated for combatting many common anemias and for correcting mild B complex deficiency states. It may also prove useful for promoting growth and stimulating appetite in poorly nourished children. (Not intended for treatment of pernicious anemia.)

Dosage: 1 or 2 teaspoonfuls t.i.d.

Supply: Bottles of 8 ounces and 1 pint.

1 teaspoonful (5 cc.) supplies:

Elemental Iron (as ferric ammonium citrate and colloidal iron)	38 mg.
Vitamin B_{12} activity concentrate	4 mcg.
Thiamine mononitrate	1.0 mg.
Riboflavin	1.0 mg.
Niacinamide	5 mg.
Pantothenic acid (Panthenol)	1.5 mg.
Pyridoxine hydrochloride	0.5 mg.

Alcohol content: 12 per cent

RUBRATON

SQUIBB IRON, B COMPLEX AND B_{12} VITAMINS ELIXIR

"RUBRATON"® IS A SQUIBB TRADEMARK

SQUIBB

Squibb Quality—the Priceless Ingredient.

KNOX PROTEIN PREVIEWS

Overcoming Today's No. 1 Nutritional Problem

Knox "Choice of Foods" Diet Can Help Your CARDIAC Patients Lose Weight Successfully

1. Color-coded diets of 1200, 1600 and 1800 calories are based on nutritionally-sound Food Exchanges.[1]

2. Easy-to-use Food Exchanges (referred to in the Knox booklet as Choices) eliminate calorie counting by patient.

3. Diets promote accurate adjustment of caloric levels to the special needs of the patient yet allow each individual considerable latitude in the choice of foods.

4. More than six dozen appetizing, low-calorie recipes are presented on the last 14 pages of each diet booklet.

1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

Chas. B. Knox Gelatine Co., Inc.
Professional Service Dept. SJ-24
Johnstown, N. Y.

Please send me ..... dozen copies of the new illustrated Knox Reducing booklet based on Food Exchanges.

Your Name and Address

(Continued from page 1049)

ton, of Gulfport; a son, James F. Thurston, of Clearwater; and a brother, Herbert M. Thurston, of Tacoma, Wash.

Rollin David Thompson

Dr. Rollin David Thompson of Coral Gables died in a local hospital on Nov. 25, 1956. He was 66 years of age.

Dr. Thompson was born in Black River Falls, Wis., on April 29, 1890. He received his medical training at the University of Illinois College of Medicine and was awarded the degree of Doctor of Medicine by that institution in 1914. He then served an internship at the Milwaukee County Hospital, Milwaukee, Wis.

During World War I, Dr. Thompson served as a captain in the Thirty-Second Infantry Division in France.

Dr. Thompson devoted his practice to diseases of the chest and spent many years in administrative work in this field. He served as superintendent of the County Sanitarium in Kalamazoo, Mich., for five years, and of the State Sanatorium at Statesan, Wis., for 10 years before coming to Florida. In this state he was instrumental in the organization of tuberculosis institutions at Orlando, Tampa, Marianna and Lantana. He was superintendent of the central Florida Tuberculosis Hospital in Orlando for 12 years and was serving the South East Florida Tuberculosis Hospital at Lantana when he retired from state service on Nov. 1, 1951. Thereafter, he resided in Coral Gables and was Consultant in Chest Diseases to the Veterans Administration. For some years he was Advisor in Tuberculosis to the Federal Hospital Council.

A member of the Palm Beach County Medical Society at the time of his death, Dr. Thompson was a past president of the Orange County Medical Society. Since 1937 he had held membership in the Florida Medical Association and he was also a member of the American Medical Association. He was a member of the executive committee and of the board of directors and a past president of the National Tuberculosis Association. He also held membership in the American Trudeau Society, the Florida Trudeau Society and the Southern Tuberculosis Conference.

Surviving are the widow, Mrs. Elda Thompson, of Coral Gables; two sons, David Thompson, of Middletown, Ohio, and Frederic Thompson, of Orlando; one brother, two sisters and four grandchildren.

Both CENTRAL and PERIPHERAL control of cough

SYNEPHRICOL® cough syrup

ANTITUSSIVE • DECONGESTANT • ANTIHISTAMINIC

Combines:

Central Antitussive Effect — mild, dependable
Topical Decongestion — prompt, prolonged

plus Antihistaminic and Expectorant Action

Winthrop LABORATORIES
NEW YORK 18, N. Y.

Synephricol, Neo-Synephrine (brand of phenylephrine) and Thenfadil (brand of thenyldiamine), trademarks reg. U.S. Pat. Off.

Each teaspoonful (4cc.) contains:

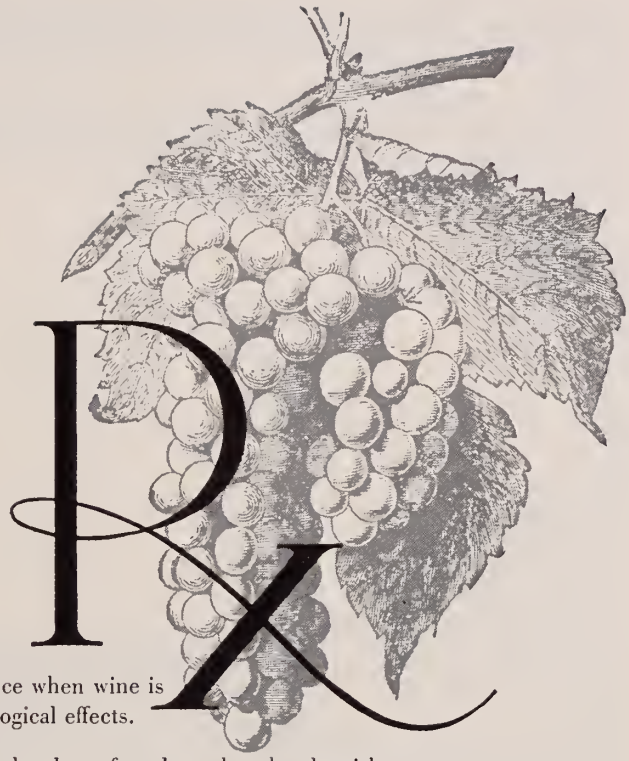
Neo-Synephrine® hydrochloride	5.0 mg
Thenfadil® hydrochloride	4.0 mg
Dihydrocodeinone bitartrate	1.33 mg
Potassium guaiacol sulfonate	70.0 mg
Ammonium chloride	70.0 mg
Menthol	1.0 mg
Chloroform	0.02 cc
Alcohol	8%

Bottles of 16 fl. oz.

EXEMPT NARCOTIC

"À VOTRE SANTÉ"

(To Your Health)



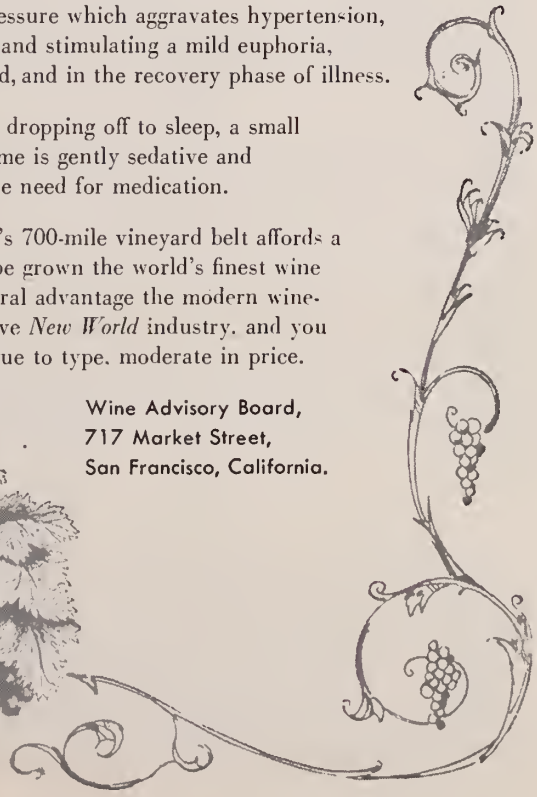
In any language, the traditional toast to good health takes on a meaning of more than passing significance when wine is used for its established physiological effects.

The carminative action of wine has been found to whet the sluggish appetite of the anorexic, post-surgical or convalescent patient; the mild secretory stimulation that follows the ingestion of wine is beneficial to the lax and generally achlorhydric stomach of old age; prudent quantities of wine are helpful in reducing the emotional pressure which aggravates hypertension, encouraging a generalized vasodilatation and stimulating a mild euphoria, so gratifying to the hypertensive, the aged, and in the recovery phase of illness.

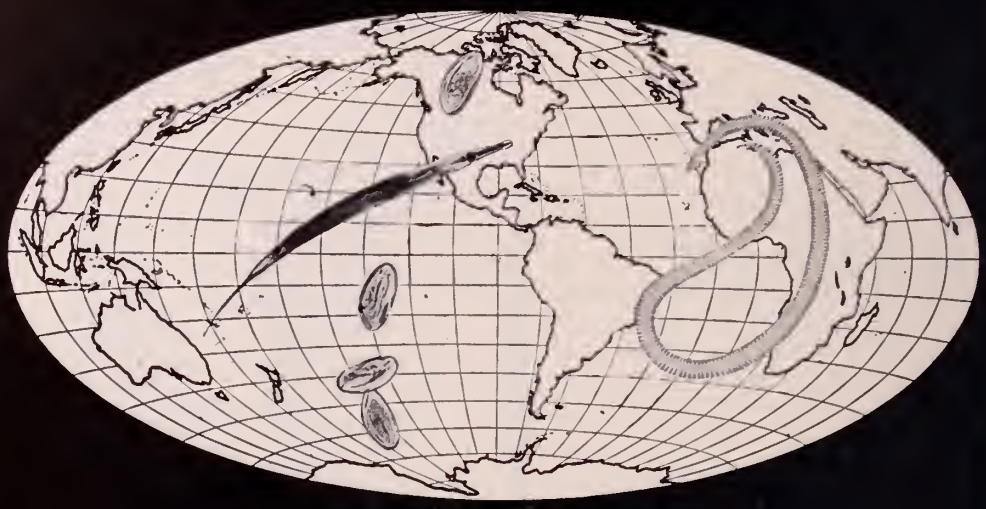
And for the patient who has difficulty in dropping off to sleep, a small amount of Port or Sherry taken at bedtime is gently sedative and sleep-producing—frequently obviating the need for medication.

The Fine Wines of California—California's 700-mile vineyard belt affords a range of soils and climate in which can be grown the world's finest wine grapes of every variety. Add to this natural advantage the modern wine-making skills and facilities of a progressive *New World* industry, and you have wines of strict quality standards, true to type, moderate in price.

Wine Advisory Board,
717 Market Street,
San Francisco, California.



for "This Wormy World"



Pleasant tasting

'ANTEPAR'® brand

PIPERAZINE

SYRUP · TABLETS · WAFERS

Eliminate **PINWORMS IN ONE WEEK**
ROUNDWORMS IN ONE OR TWO DAYS

PALATABLE • DEPENDABLE • ECONOMICAL

'ANTEPAR' SYRUP – Piperazine Citrate, 100 mg. per cc.
'ANTEPAR' TABLETS – Piperazine Citrate, 250 or 500 mg., scored
NEW 'ANTEPAR' WAFERS – Piperazine Phosphate, 500 mg.

Literature available on request

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Mrs. John R. Browning, Yearbook.....*Jacksanville*

End of Year Near

As the end of the year comes near, the Woman's Auxiliary to the Florida Medical Association finds it has done a superb job of supporting the programs and projects of the national auxiliary and has had outstanding results with the programs it has carried out.

The county auxiliaries remain enthusiastically in favor of our programs and projects and show that enthusiasm through all-out support of them. The final reports will show excellent results.

Mrs. Scottie J. Wilson, our charming and very efficient president, has been busy planning the convention and seeing that the reports of officers, committee chairmen and county auxiliaries are all on hand in time to be included in our printed reports handed out at the convention to the delegates. Mrs. Robert Flanders, President, Woman's Auxiliary to the American Medical Association and Mrs. O. W. Robinson, President, Woman's Auxiliary to the Southern Medical Association, have both been invited as guests of honor at the convention. Mrs. Flanders has made

(Continued on page 1060)

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While discussing purulent cellulitis and sepsis due to staphylococci, Eastman, et al., mentioned erythromycin as a *drug of first choice in treating these conditions.*[2]

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1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 34, New York, Medical Encyclopedia Inc., 1955. **2.** Eastman, G., Cook, E. and Bunn, P., N. Y. State J. Med., 56:241, 1956. **3.** Solomon, S. and Johnston, B., Amer. J. Med. Sc., 230:660, 1955.

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(Continued from page 1057)

her plans to come and her husband, Dr. Robert Flanders, of Manchester, New Hampshire, will accompany her. With so many conventions at one time, Mrs. Robinson is trying to arrange her schedule to include Florida as well. We will all be happy to welcome these two to our convention. Mrs. Robinson is from Paris, Texas, by the way, and of course Mrs. Flanders is from Manchester, New Hampshire.

Presented for ratification at this convention will be a charter as a non-profit corporation and new By-laws. If these are ratified by the House of Delegates, the charter will be taken to the circuit court to be authorized and the Woman's Auxiliary will have become a non-profit, educational and philanthropical corporation. The program and projects will remain the same as all those thus far followed by the auxiliary have been of an educational and philanthropical nature.

The new officers of the auxiliary, headed by Mrs. Perry D. Melvin who will move from President-Elect to President, will be elected and also delegates to the 1957 meeting of the House of Delegates of the Woman's Auxiliary to the American Medical Association. This meeting will be held in New York City, June 3-7 at the Roosevelt Hotel.

Under the excellent and outstanding leadership of Mrs. Wilson, the Woman's Auxiliary to the Florida Medical Auxiliary closes another progressive and outstanding year. We feel that we, in Florida, are fortunate to have had such excellent leadership and that with the supply of talent we have, we can look forward to many more years of superior work.

We could not close out a year of the column devoted to the Woman's Auxiliary to the Florida Medical Association without thanking the officers of the Florida Medical Association, headed by Dr. Francis H. Langley, and the staff at the Florida Association offices, headed by Mr. Ernest Gibson, for their interest, sympathetic understanding and help given us throughout this year. To them we wish a most happy and successful convention.

Mrs. Richard F. Stover

Program

The program for the Thirtieth Annual Meeting of the Woman's Auxiliary to the Florida Medical Association is published in this issue of The Journal beginning on page 1013.

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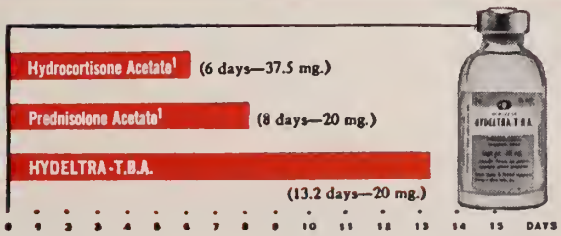

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1. Hollander, J. L., *Paper read at conference in New York City, May 31 and June 1, 1955*

(*Continued from page* 1020)

AMES CO., INC — 86

The Ames exhibit will introduce a new and unique concept in sedation — a new calmative drug — NOSTYN. NOSTYN is chemically and physiologically unrelated to any available compound. NOSTYN allays anxiety and tension with the power of gentleness; possessing a wide margin of safety, NOSTYN, avoids depression or drowsiness.

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HART DRUG CORP. — 91

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The National Formulary. American Pharmaceutical Association. Pp. 867. Ed. X. Price, $9.00. Philadelphia, J. B. Lippincott Company, 1955.

The tenth edition of the National Formulary is the fourth to be published according to a plan adopted by the Council of the American Pharmaceutical Association in 1938 for the issuance of revisions at five year intervals. This plan, together with a provision for the issuance of Interim Revision Announcements and Supplements, makes it possible to keep the National Formulary abreast of the rapid development of new drugs and to issue interim revisions promptly when needed.

In this edition, substantial changes in the content of the text have been made. A total of 242 of the 717 drug items official in N. F. IX were not admitted to N. F. X. Titles and standards for 259 drugs, for which official standards would not otherwise be provided, were added to N. F. X. during the revision program. In the process of revision, many individual specifications for strength, quality, purity, and identity were revised and materially improved. Among new features are specifications for the disintegration time of coated, buccal, and sublingual tablets and weight variation standards for the content of dry-filled capsules and for solubility of hypodermic tablets. The general chapters on injections and sterility tests have been revised, and a new chapter on general sterilization procedures has been added. Also, a new section on general information has been included.

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Southeast	R. M. Overstreet Jr., W. Pm. Bch	Ralph S. Sappenfield, Miami	Fort Pierce
la Specialty Societies			
my of General Practice	Leo M. Wachtel, Jacksonville	Charles D. Cooksey, Jacksonville	Hollywood, May 5, '57
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na Medical Association	Grady O. Segrest, Mobile	Douglas L. Cannon, Montgomery	Mobile, April 18-20, '57
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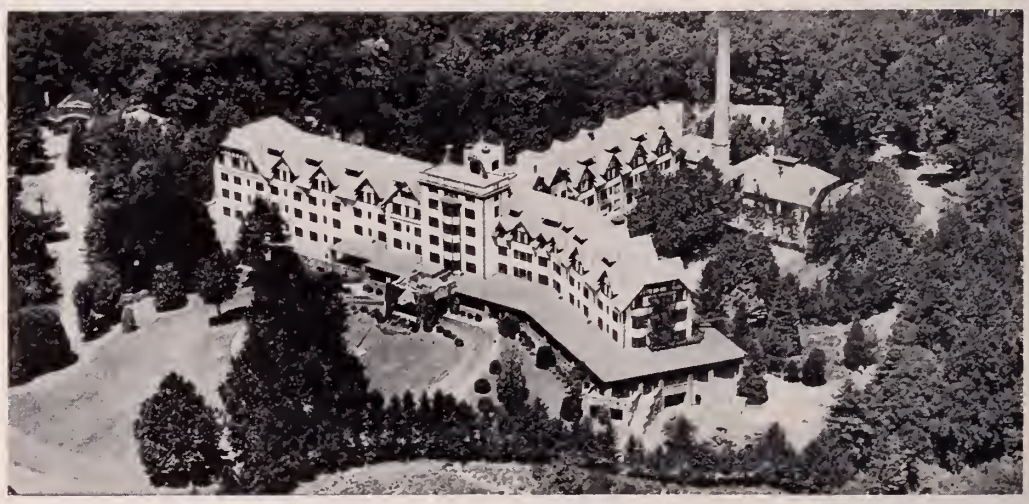

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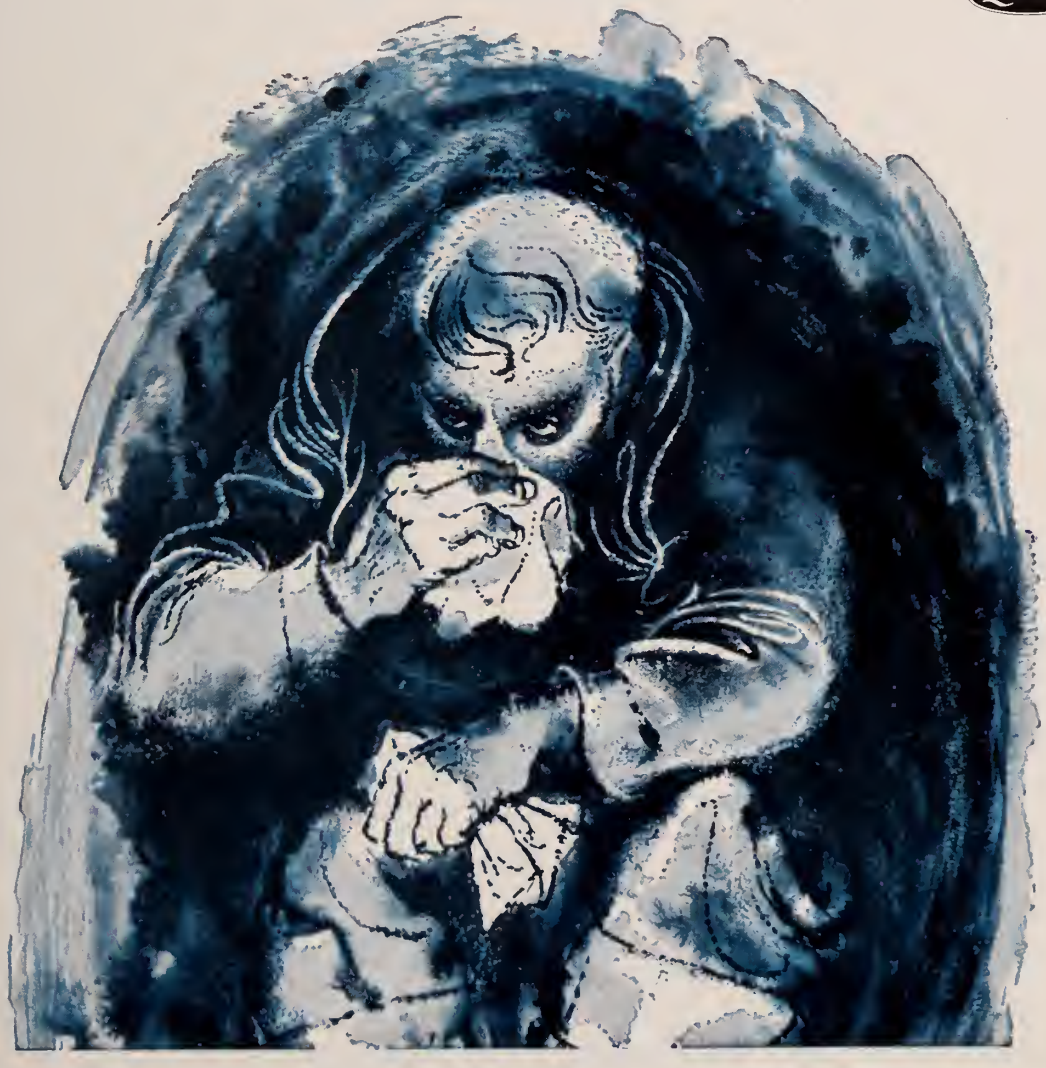

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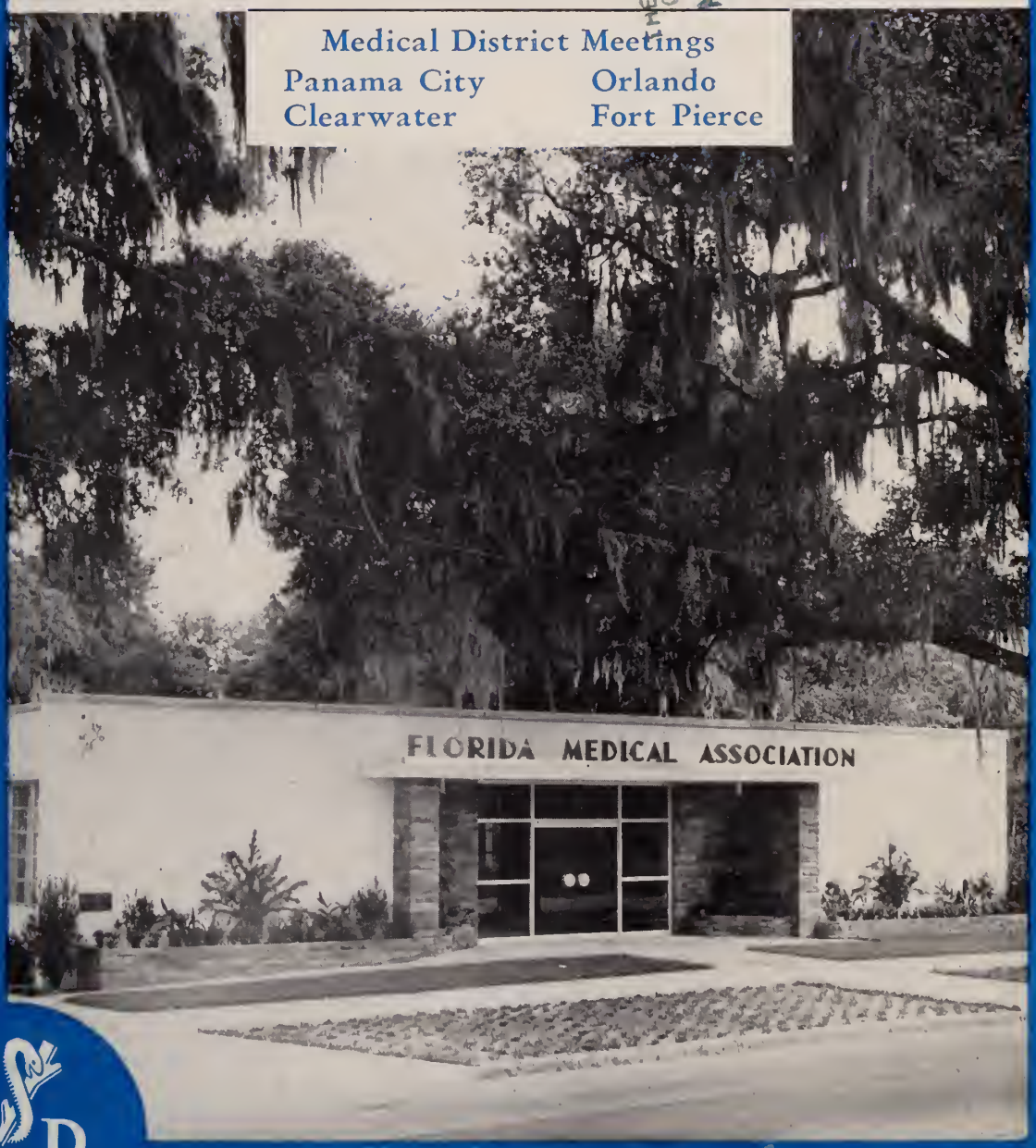

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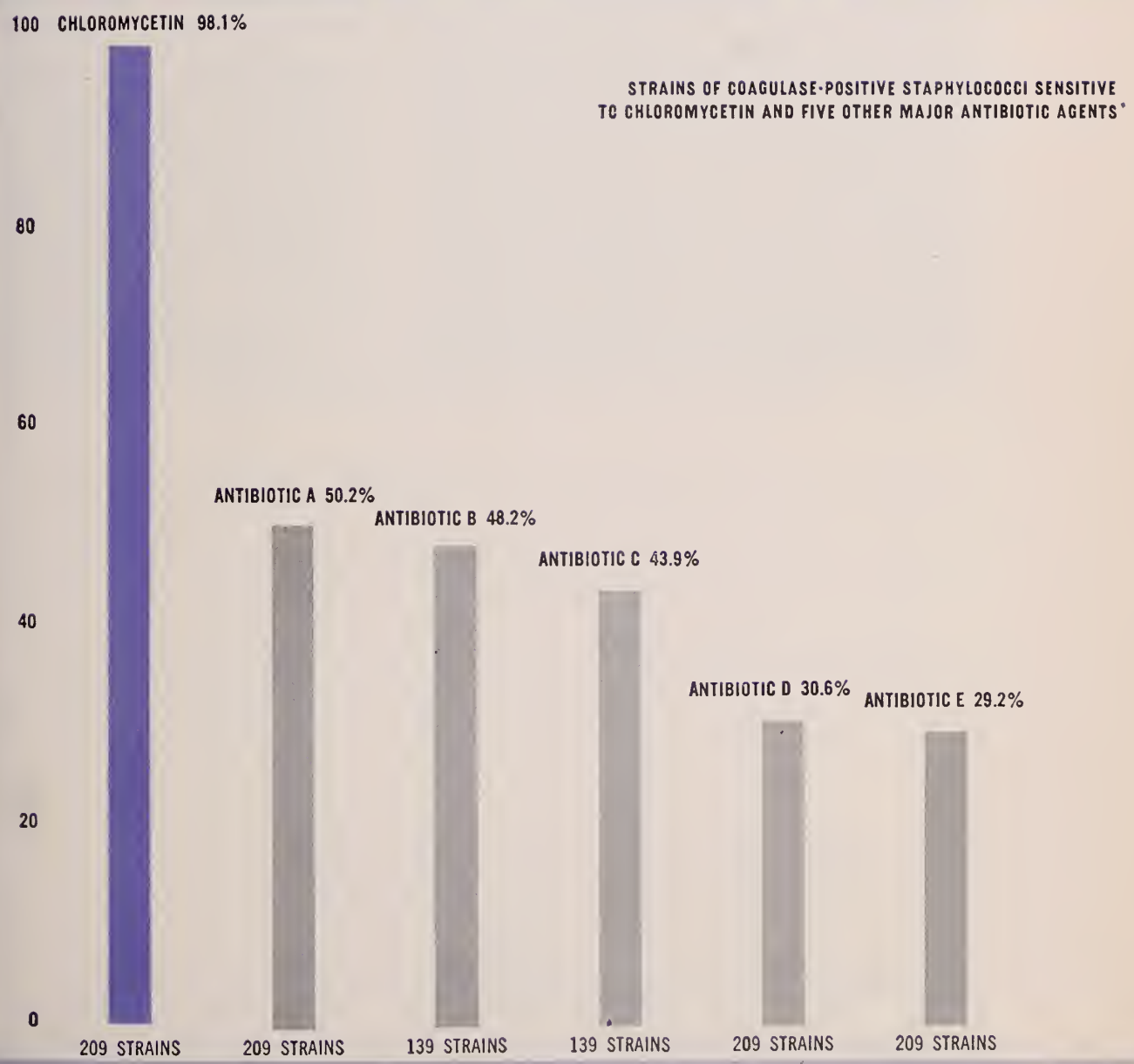

*This graph is adapted from Spink.[2]

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1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954

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This is not to suggest, of course, that side effects will n
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the mildness of side effects, in the few instances in wh
have been reported, suggests Harmonyl as a drug of
conditions ranging from mild anxiety to major ment
and in essential hypertension.

Why fewer and less severe side effects?

Some investigators suggest that the evidence of less p
pathetic effect with Harmonyl in animals might also b
man. In chronic toxicity studies with Harmonyl this w
fested by less diarrhea, "bloody tears" and ptosis in r
was observed with the same dosage of reserpine. Dog
hibited milder side effects—in particular, diarrhea.
toxicity or hematological change was observed with H
over a wide dosage range.

Harmonyl as a tranquilizer

While Harmonyl's safety is most impressive, clinical i
tors reported other notable characteristics for this wi

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ilizer. For instance, following an eight-month study of :, hospitalized mental patients, Ferguson[1] reported:

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monyl was more potent in controlling aggression, ng only one-half to two-thirds the dosage of reserpine.

umber of patients experiencing side reactions on ne were completely relieved when changed to Harmonyl.

summary Ferguson concluded: "*The most notable im- ns were the absence of side effects and relatively rapid f action with Harmonyl.*"

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s In mild anxiety, as little as 0.1 mg. of Harmonyl a y be effective. In institutionalized psychiatric patients, than 2 to 3 mg. a day is likely to be beneficial.

essential hypertension, treatment may be started with 5-mg. tablet three or four times a day. After about ten r sooner, depending upon response), dosage may be re- A maintenance dose of 0.25 mg. daily is often sufficient.

tions, As with other forms of rauwolfia, Harmonyl used cautiously in peptic ulcer and epilepsy and in about to undergo surgery or electroshock treatment. infrequent reports involving depression, patients with y of depressive episodes should be watched carefully.

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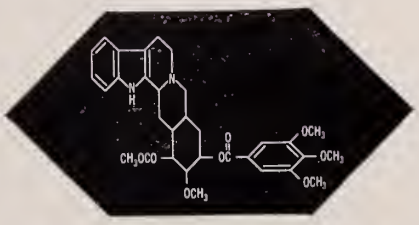

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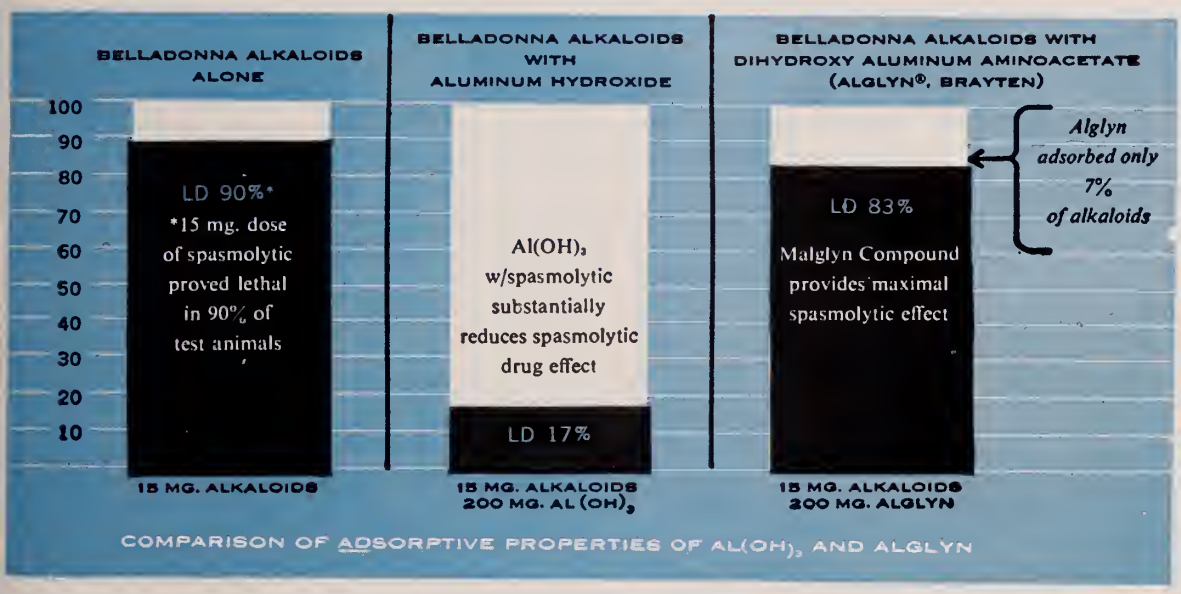

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Ulcerative Proctitis

THOMAS E. MCKELL, M.D.
TAMPA

That form of chronic ulcerative colitis of unknown cause and limited to the rectum or to the rectum and lower sigmoid colon is the topic of this discussion. Amebic and bacillary dysentery infections, drugs, factitial agents and other causes which may produce an inflammatory reaction in this area were eliminated by adequate studies in all cases discussed.

Clinical papers on idiopathic ulcerative colitis are apt to be devoted largely to the severely ill patient whose care demands the utmost skill in management of nutrition, antibiotics, psychotherapy, electrolyte balance and adrenocorticotropic agents, and judgment as to when surgery may be necessary. In more comprehensive reviews mention is made that mild forms of the disease confined to the lowest part of the bowel are seen, and that these may comprise a large part of the total cases diagnosed. Bargen[1] reported this group representing 20 per cent of the total, but others have observed that it represents as high as 39 per cent.[2] An even more startling figure is given by Steele and Brown,[3] who tabulated the results of 1,500 routine proctosigmoidoscopic examinations. They found three cases which were classified as typical ulcerative colitis, but an additional 40 cases with pinpoint ulcerations which they believed represented early or mild ulcerative colitis.

The wide variations in incidence are hard to explain. It has been noted that the disease is less prevalent in the warmer areas of the United States,[4] but such variations would seem to be outside any possible climatic difference. Some authors[5,6] have described a benign lesion which they classify as "idiopathic granular proctitis" separate and distinct from true chronic ulcerative colitis. Such an entity might explain some of the high incidence of proctitis noted. The difficulty with this hypothesis is that in none of their descriptions of the lesion or accounts of its clinical course is offered a means of differentiating it from the localized form of ulcerative colitis which may not remain so benign.

Analysis of Series

All patients in the series presented were subjected to proctoscopic examination several times and had at least two stool examinations and cultures, a barium enema and whatever skin tests, roentgen examinations and other studies were necessary to rule out other cause for the lesion. Several were given amebicidal drugs with no benefit. A personality evaluation was attempted in each. It is noteworthy here that while I was in New Orleans, Dr. Sullivan, one of the pioneers in psychosomatic medicine, and I observed 14 patients and were not too impressed with any significant deviation from the normal. In the ones seen since I have been in private practice, six of the seven appeared to have a definitely abnormal personality pattern. I think the difference is that I have come to know these latter patients much better.

Table 1 contrasts the features of ulcerative proctitis and colitis and granular proctitis.

The presenting complaint of the patients under consideration was bleeding from the rectum. They might or might not have some increase in bowel frequency, but rarely was there any severe diarrhea. Some might even be constipated and note blood occurring only with the passage of a hard stool. Symptoms might be present intermittently or continuously for weeks, months or even years. My experience has been that systemic signs and symptoms such as fever, loss of weight, anemia, and an elevated white blood cell count or sedimentation rate did not occur except as portents of a spreading process which had or was about to remove the disease from the benign category. Physical examination was not helpful except with the proctoscope. Here one saw a mucosa which had not the normal, satiny sheen with its lacy network of tiny connecting vessels. Rather it was coarse and granular in appearance

Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami Beach, May 14, 1956.

Table 1. — Characteristic Features of Ulcerative Proctitis, Ulcerative Colitis and Granular Proctitis

	Ulcerative Proctitis	Ulcerative Colitis	Granular Proctitis (?)
Bleeding	+	+	+
Diarrhea	±	+	±
Systemic symptoms	0	+	0
Etiology	?	?	?
Clinical course	Usually benign	Severe	Always benign
Proctoscopic	Granular, friable	Same or worse	Granular, friable
Barium enema	—	+	—

and bled when wiped with a wisp of cotton. This process might be limited to a few inches of the rectum with the mucosa beyond entirely normal, or it might extend into the lower sigmoid. In the area affected there was total involvement with no intervening areas of normal mucosa. Edema was minimal, and if significant edema or gross ulceration began to appear, there was usually a more extensive upward involvement of the bowel. The barium enema revealed no damage above the lower portion of the sigmoid colon.

Now, if this were the entire picture of the disease, one might end here by simply pointing out that there is a rather benign ulcerative proctitis which one must recognize, but even if one cannot or does not do much about it, the patient will not suffer greatly.

It is unwise to accept such a view. In this series of 20 cases, there was a history of one or more previous severe attacks of colitis in four, with a typical toxic and protracted debilitating course. In addition, in three cases the initial process was indistinguishable from the one described, but after some weeks or months there suddenly developed a typical severe and extensive ulcerative colitis involving most of the large intestine (table 2). It has been generally recognized that this possibility may occur.[1,7] More specific means of treatment might spare the patient in such cases the severe form of this disease.

Table 2. — Ulcerative Proctitis, Severity

Total Cases	Previously Severe	Progressed to Severe
20	4 (20%)	3 (13%)

Treatment

As far back as 1946, after reading Dr. Borland's paper[8] on the treatment of milder cases of ulcerative colitis with long term and heavy sulfonamide doses, Dr. Sullivan and I, at the Ochsner Clinic, adopted his method of treatment in cases belonging in this category. We did not achieve quite as good results as he, but we did get some 70 per cent remissions with the sulfonamides and observed a few more beneficial results from Aureomycin. Even so, it required prolonged therapy at high dosage levels of the drug, not without some possibilities of toxicity. Our experience also was that frequent courses of the drug had to be given to keep the disease in remission.

In 1952, some time after beginning private practice in Tampa, I adopted the use of the adrenocorticotropic agents in the same type of case, having seen myself[9] and learned from others[10] of the good results sometimes observed with the use of these agents even in the severe forms of ulcerative colitis.

Seven cases have been seen in four years. Table 3 summarizes the results. In six, the patient was treated with ACTH, cortisone or Meticorten. One patient refused the use of these drugs because she was afraid of them. She has had five recurrences in a three and a half year period, whereas the total recurrences experienced by the other six numbered only three.

Table 3. — Results of Therapy in Seven Cases of Ulcerative Proctitis

Cases	Prior History (Years)	Effective Drug	Recurrence	Follow-Up (Years)	Significant Neurosis
1	0	Sulfonamides	1	4	Moderate
2	0	Cortisone	1	3.5	Severe
3	15	ACTH	1	2	Mild
4	7	Cortisone	0	1	Moderate
5	3	Cortisone	0	3	0
6	0.5	Meticorten	0	0.5	Moderate
7	7	?	5	3.5	Severe

In five of the six patients, the mucosa reverted to normal under treatment. In four of the five, this treatment was on an outpatient basis with relief occurring within a week and with the bowel mucosa appearing entirely normal within three weeks. One patient did not show improvement on cortisone; the white blood cell count rose to 19,000, and he was hospitalized. On ACTH a remission occurred within a week. Treatment with small doses was continued for another three weeks. He has had one slight recurrence since with no systemic signs or symptoms. This was promptly controlled with Meticorten.

Another patient was treated initially with cortisone, but there developed a severe respiratory infection some 36 hours later. The drug was

discontinued, and he could not be persuaded to resume treatment with it since he was convinced it had something to do with this infection. There was response, after several months, to treatment with sulfonamides. One minor recurrence about a year ago was successfully controlled with Meticorten in less than two weeks.

The dosage of cortisone usually was started at 100 mg. per day in four divided doses. This amount was gradually decreased after a few days, or as bleeding became less. Treatment with Meticorten was usually begun in dosage of 5 to 10 mg. four times daily. In the one case in which the use of ACTH was necessary, the patient was given 30 units of the gel daily for three days, and then the amount was gradually reduced. As an outpatient, he was given first 10 and later 5 units every other day.

Summary

Ulcerative proctitis is a relatively benign form of chronic ulcerative colitis. It must be closely watched and treated since it may become severe at any time.

Differentiation from the more severe form of chronic ulcerative colitis is chiefly through lack of systemic signs and symptoms and failure to demonstrate pathologic change above the lower portion of the sigmoid colon.

Sulfonamides have been found to be of value in its treatment, as had been reported earlier.

ACTH, cortisone and the other more recent derivatives of cortisone have been found to be highly effective in treatment.

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Citizens Building.

Discussion

Dr. Frank C. Bone, Orlando: I enjoyed Dr. McKell's paper and am glad that he has emphasized this mild, frequently undiagnosed form of chronic, nonspecific ulcerative colitis. I should like to be certain that he considers it a form of this disease and not a separate entity. As he has mentioned, the diagnosis can be made only on sigmoidoscopy, since examination by barium enema will usually give normal results. These patients often have formed stools, and the bleeding is attributed to hemorrhoids. Consequently, any patient who passes blood should be sigmoidoscoped. Not only will this lesion often be found, but polyps and carcinoma as well.

In a series of 112 patients with chronic, nonspecific ulcerative colitis, which I had the opportunity of studying several years ago, approximately 15 per cent had this form of the disease. Sixty-five of the group had serial barium enemas over a period averaging six years. In 20 per cent of this number there was roentgen evidence of progression of the extent of involvement of the colon; in 70 per cent there was no change in the areas of the colon involved, and in 10 per cent there was diminution in extent of the disease. Although in most of the patients with this disease there is no progression of the extent of involvement, there is involvement of virgin areas of the colon in enough patients to make physicians do all in their power to prevent this progression.

In any disease such as this, with spontaneous remissions and exacerbations, the evaluation of any form of therapy is indeed difficult. It has been my impression that the steroids will usually induce a remission in this disease, but aside from this effect they probably do not change the subsequent course of the disease. I should like to have Dr. McKell comment on this matter. His series would suggest otherwise, but for statistical purposes the number is small.

One of the best ways of evaluating the results of management is by serial sigmoidoscopy. More often than is usually realized, the appearance of the rectal mucosa will revert to normal. Dr. McKell noted this change in four patients. In our group, 41 per cent at one time or another had a perfectly normal rectal mucosa. This does not necessarily mean, however, that these patients will not have future recurrences of the disease. I would certainly agree with Dr. McKell that these patients should be treated vigorously and respectfully. I also believe that our most potent medical weapon at present is the steroids, and they should not be withheld. I usually treat such patients first, however, with diet, poorly absorbed sulfonamides, sedatives and antispasmodics. If after a short trial, insufficient improvement is noted, I use ACTH without further delay.

Dr. James L. Borland, Jacksonville: Dr. McKell's fine presentation illustrates the oft repeated but rarely appreciated basic tenet that the diagnosis of nonspecific ulcerative colitis really embraces many disease patterns. One major criticism of the current medical literature is that it fails to do that which Dr. McKell has done, mainly to classify properly the disease pattern that he is discussing and to use only comparable cases. I believe that much of the controversy that rages about the disease stems from the fact that often physicians are talking about different diseases. These cases that Dr. McKell has shown are not at all comparable to the hose pipe colons or to the diffuse highly toxic or hyperplastic bowels that are widely described in the literature. To attempt to apply any treatment or prognosticate, all by the same standard, is folly.

There is no question in my mind that, whatever the reason, there exists a geographic distribution in these diseases. A chronic ulcerative colitis of the type of the severe toxic, or hose pipe or hyperplastic types is rarely seen in the gastrointestinal clinic of the Duval Medical Center. As a matter of fact, between the years 1937 and 1941, no cases were seen in the clinic, although they were encountered in private practice. This is a large outpatient clinic, and during those years the proctoscopic and the gastrointestinal clinics were operated in one. I do not think such cases were being missed. The reason for their absence I do not know. I simply give the figures. There has been a slow increase in the years that have followed, but still it is unusual to see ulcerative colitis in this clinic.

In private practice the type described by Dr. McKell is the usual one, and I should like to emphasize again the criteria delineating this particular condition. We must restrict the classifications, or else we wander afield. The first criterion of this type is that there must be no general sign of disease or toxicity. This is important. I think that cases in which there have been severe breaks in the past history, or in which they eventually occur, are not properly classified. I have the feeling in my own mind that I can tell from the general history of the patient the type of the disease that is present, and I think this lack of toxicity is important in the prognosis.

The second criterion is that the disease must begin at the internal rectum and it must decrease and finally disappear before the upper limits of the sigmoidoscopic examination are reached. It is reasonable to assume, of course, that in some cases the disease will extend beyond the reach of the sigmoidoscope, but in that event one has no assurance that it does not extend higher and that it is not a separate disease. I think it is necessary, therefore, to adhere to this criterion.

Third, there must be no hyperplasia of tissue, pronounced contraction of the rectum, stricture, or, as Dr. McKell has mentioned, large ulcerations.

In summary, this type of ulcerative colitis is a simple benign granular proctitis which disappears as it goes upward, and as it heals, it heals from above downward. One may readily observe this type of spread and regression.

Do the acute phases in Dr. McKell's cases represent separate entities or not? I personally believe that they do and should not be included. My experience, without a large series but extending back to 1937, is that the various manifestations of ulcerative colitis as seen in Florida, at least in Duval County, are type-stable. We are now seeing, however, a queer type of ulcerative colitis, beginning in acute episodes indistinguishable from bacillary dysentery. They can be extremely acute; the lesions will disappear, then return again. Improvement occurs on antibiotics. They differ from those of bacillary dysentery in that they tend to reappear each spring, and the bowel is not entirely normal between the episodes. What they are I do not know, but it has long been believed that some cases of ulcerative colitis begin in bacillary dysentery. For instance, Dr. Hurst in the first World War saw patients gradually go from proved bacillary dysentery into ulcerative colitis of all types including these of proctitis. Dr. Hurst originally treated the lesions with antibacterial serum. Perhaps we are seeing now this type, and these acute cases of Dr. McKell could be these proctitises.

In setting out a plan of treatment for the individual case, consideration must be given to the thesis that ulcerative colitis is not one but many diseases. Certainly the response to treatment discloses a high degree of variability between individuals and a "successful series" may be obtained with almost anything. In a series of 50 consecutive cases treated with sulfonamides at high levels, I applied the principle discovered in bacillary dysentery that the sulfonamide level must be in excess of 12 and maintained there for a period of time. We had no trouble keeping up this therapy for as long as a month and then followed it with suppressive treatment. In all, the disease disappeared. Following my report of that series, I had two more cases in this country respond. I had no further response, however, to the sulfonamides following the publication of my report for two or three years, and I realized later that I was applying the treatment to different types of cases, such as hose pipe and those cases of diffuse granular nature, which do not respond in the same way. That has been the experience with all types of treatment of ulcerative colitis. You start, you have a series, the patients improve and then they do not anymore. The literature is full of successful treatments of ulcerative colitis which have then failed.

This variation may be due to the fact that we are not adequately classifying that of which we are speaking.

I am impressed by the use of cortisone in the particular type that Dr. McKell presents, but his results must be tempered by the observations just mentioned. There is, of course, good sound reason for the use of steroids, but there is some danger in my mind in the use of this therapy — not only the publicized dangers such as the induction of bacteremia, perforation, the development of resistance, and the advancement of infection, but the point that in this type the patients will gradually get well anyway. The thing to do is to use the least degree of treatment that is of benefit and follow the patient. In other words, instead of giving everything and treating intensively, one treats this type as little as possible and adds therapy only as it fails to improve. Whatever induces a recurrence the first time will induce a recurrence the second time if the same treatment is followed. Dr. McKell has found in the use of cortisone that it will greatly shorten the period of treatment. There is some question here, however, as to whether in the use of this drug one teaches the patient to take care of his particular disease.

I congratulate Dr. McKell on his paper. I have enjoyed it very much.

DR. DONALD F. MARION, Miami: I shall abuse the prerogative of the chair to report only this brief word or two about ulcerative proctitis as we see it here in our clinic at Jackson Memorial Hospital and as quite a number of us apparently more or less agree we see it in our private offices. The entity is real. You have been impressed, I am sure, by the reluctance to attempt to classify it too rigidly. Yet, we have also heard that without classification we are lost. It is a paradoxical situation. If you look into the rectum, there is no doubt whatever, whether you are experienced or relatively inexperienced, that you are looking at disease. When you follow the patients, however, sometimes for four, five or more years —it has been my privilege to follow a few of them for as long as 10 years, and I am sure Dr. Borland has followed some longer than that—you cannot help being tremendously impressed that you are looking at something extremely benign, like certain of the more benign forms of psoriasis possibly or even some of the more benign forms of recurrent atopic dermatitis or other types of allergic skin manifestations.

Naturally, someone has to mention allergy whenever you are dealing with a situation like this. So I shall mention it. Many persons take it extremely seriously, and one or two of them will tell you themselves that their rectal bleeding is ever so much more pronounced and noticeable after the use of certain food stuffs. Laziness alone, I think, is the major reason which prevents us from following through every case with the attempt to investigate food allergies in the creation not only of this odd ulcerative picture at the distal end of the gastrointestinal tract but possibly a picture not unlike it that you may see at the opposite end in the oral cavity. So there are certain similarities between some of these odd recurrent ulcerations, although they do not look the same and are not the same pathologically. The sequence of events, however, is so strikingly similar that frankly I am way up a tree about the possibilities of a similar etiology; the idea, however, is tempting.

Since of course the cases we have seen here in Dade County are for the most part extremely benign, I personally have grave doubts about the wisdom of treating the patients with corticosteroids. I am most reluctant to do so. As a matter of fact, I can think of only one case I personally have ever seen in which I know for sure the disease progressed to involve more of the colon. It has been my impression that in most of these cases the disease is limited to the rectum and limited there for all time. I do not say that it cannot progress. I do think that it is a variety of chronic ulcerative colitis, which, as you all know, is unfortunately a wastebasket term. We know nothing whatever about etiology, and all we are hoping to do at present is to learn more about the disease, as we have been doing for a generation or more. I am, however, interested in Dr. McKell's results, treating these patients with Meticorten particularly, and I am somewhat interested in his dosage—the implication that he has started with 100 mg. of cortisone. I wonder how long he has kept it up, and I wonder if there is such a thing as a maintenance dose that would be a small enough dose to be innocuous. With all these questions, Dr. McKell, I wonder if you would have any closing remarks that you would care to make?

Whiplash Injuries of the Spine

Lyle W. Russell, M.D.
MIAMI

With the incidence of whiplash injuries of the spine increasing proportionately with the number of automobiles on the streets and highways of this country, it is becoming more and more important for every doctor to be aware of the seriousness of what may seem to him at first to be a trivial injury. My observations in the course of examination and treatment of 150 patients with whiplash injuries of the spine during the past three years form the basis for this paper.

The majority of these injuries are caused by automobile accidents, and of these most are rear end collisions. Similar effects, however, can be produced by head-on or side collisions. A sudden acceleration of a standing or slowly moving car, or a deceleration of a rapidly moving car, produces a sudden movement of the head toward the direction of the applied force and then a recoil in the opposite direction. Because the lower thoracic and the upper lumbar regions are supported by the back of the seat, the cervical and upper thoracic regions receive the greatest damage and the lower lumbar region the next greater strain. The exact position in which the occupants of a car are sitting determines to some degree the extent and anatomic location of the spinal injury. If they are relaxed, without any warning of an impending crash, a mild impact can produce the same effect as a hard impact does when they have an instant of warning and the muscles tighten up to give a protective splinting of the spine. Thus it is impossible to judge accurately the injury to an occupant by the amount of damage to the car or by the distance which a standing car is pushed by another.

Pathology

No attempt will be made to describe in detail the pathology produced by the whiplash injuries since it has already been aptly described by many authors.[1-3] Suffice it to say that a sudden stretching of joint capsules, ligaments, muscles and nerve roots produces a varying amount of tearing of the tissues with hemorrhage and edema. Muscle spasm invariably follows in due time in all except the mild cases. Occasionally fractures are produced in the vertebrae, but they are the exception rather than the rule. When they do occur, they are found usually in the spinous processes or the bodies of the vertebrae. As the fibrous tissues heal, scar tissue is laid down among the normal fibers, thus resulting in a chronic fibrositis. In severe injuries the scar tissue formation may be so extensive as to give a permanent restriction of motion of the spine. In moderately severe injuries the scar tissue may not be dense enough to restrict motion, but may be a source of pain when any undue strain is exerted, since the tissues do not have normal elasticity. Initial irritation and edema around nerve roots frequently result in peripheral neuritis, and occasionally scar tissue around the nerve roots leaves a permanent peripheral neuritis. As has been pointed out by Jackson, herniation of an intervertebral disk rarely occurs in the cervical region, but it is not too uncommon in the lower lumbar region. In this series of 150 cases there were four cases of definite herniated disk in the lower lumbar region, but none in which there were symptoms sufficient to be particularly suggestive of a herniated disk in the cervical region.

Symptoms

The symptoms immediately following a whiplash injury are never so pronounced as they are from one to three days later. At first there is usually a somewhat stunned feeling, and there may be a vertigo. If the trauma is chiefly to the cervical and upper thoracic area, one or more of the following complaints may follow: headache; pain in the neck and upper part of the back; pain, numbness or tingling radiating down one or both arms; blurred vision; spots before the eyes; double vision; nausea; vomiting; nervousness and emotional instability. When a spasm develops in the cervical muscles, motion of the neck may be restricted in one or more directions. Downward pressure on the head often increases the pain in the neck while traction relieves it. Sensory disturbances and reflex changes are sometimes noted in the upper extremities.

Even though symptoms in the head, neck and upper part of the back may predominate, one must not overlook the lower portion of the back and the lower extremities. Usually the only

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Fig. 1.—Roentgenogram showing a compression fracture of the body of the fifth cervical vertebra.

symptom is low back pain, and on examination spasm of the paravertebral muscles may be present. In those cases, however, in which protrusion of an intervertebral disk is produced, there is radiating pain down one or both legs with sensory disturbances and reflex changes. Muscle spasm often causes a tilting of the trunk toward one side and a flattening of the lumbar lordotic curve.

Roentgen Examination

Roentgenograms of the spine should be made a part of every examination of a whiplash injury, even though in most cases they appear normal. Occasionally a fracture may be produced in some portion of one or more vertebrae (fig. 1). A mild subluxation may sometimes be demonstrated, even with the head held erect, but forward flexion of the cervical spine will show it more clearly (fig. 2). Mention is often made on a radiologist's report of a straightening or reversal of the cervical lordotic curve on a lateral view. Unless one knows the exact circumstances under which the roentgenograms were made, it is my opinion that such a report proves nothing. It is possible for cervical muscle spasm to produce a straightening or even a reversal of the lordotic curve. At the same time it is possible for an uninjured person to have a similar roentgenogram if he voluntarily tilts his head slightly forward (fig. 3). Three lateral views, therefore, should be made whenever there is any doubt and should be made under the supervision of the examining doctor. One roentgenogram is made with the neck in flexion, one with the head as erect as the patient can hold it without producing increased pain, and one with the neck in hyperextension. If the second view shows a change in the normal curve, even though the third view shows restoration of a normal curve, it is thought that this is roentgen evidence of muscle spasm. Sometimes there may be a lordotic curve in one portion of the cervical spine and a straightening or a reversal of the curve in another portion, thus resulting in a so-called "S" curve (fig. 4). When these changes persist, even months after the injury, when muscle spasm has subsided, it is believed that they indicate a fibrosis or scar tissue formation in the muscles and ligaments which prevents restoration of the normal curve.

Myelograms are indicated in those cases in which there are persistent symptoms of a herniated intervertebral disk and when surgical treatment is contemplated. In the present series of cases studied, a myelogram was performed on only one patient suspected of having a fifth lumbar herniated disk, and it gave positive evidence which was later corroborated at the time of surgery. In the other three cases of herniated disks in the lumbar region of the spine the diagnosis was made on subjective and objective symptoms, and the patients were treated with a fair degree of success with conservative management; therefore, myelograms were not performed.

Treatment

Early initiation of proper treatment is an important factor in reducing the extent of disability. An appeal, therefore, is made to the family doctor, who is usually the first one to see a patient with a whiplash injury, not to dismiss him with an assurance that there is no serious injury, even

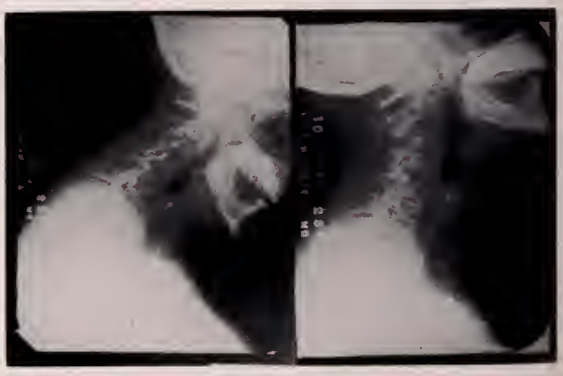

Fig. 2. — Lateral view with the cervical spine flexed showing minimal anterior subluxation of the fourth cervical vertebra on the fifth cervical vertebra more clearly than when the head is held upright.

Fig. 3. — Lateral view of the cervical spine of an uninjured person, showing how a slight forward tilt of the head can produce a straightening of the lordotic curve.

though he may have only minor complaints and no positive objective findings on first examination. It must be kept in mind that the maximal effects may not appear for from two to five days after the injury, and therefore the progress of each one must be carefully followed for several days before one decides that no treatment is necessary.

It is thought advisable to hospitalize all severely injured patients. When a patient is emotionally upset, has severe muscle spasm and pain, and a pounding headache, his condition is aggravated by having him ride back and forth to an office for treatment. In the hospital the patient can be kept at bed rest with head halter traction applied. The physiotherapist can apply soothing hot wet packs and massage to the painful spastic muscles. Intravenous Tolserol (100 cc. of 2 per cent solution in 400 cc. of saline) gives more effective muscle relaxation than any of the muscle relaxant drugs given orally. If low back and/or leg pains are present, pelvic or bilateral leg traction can be applied as well as head traction. Sedatives and analgesics are given as indicated.

When the acute symptoms have subsided, usually in one to two weeks, the patient can then be sent home and treatment continued in the office. A cervical collar, either felt or plastic, will serve to protect muscles from having more spasm and pain when the patient is walking or riding in a car. In the more severe cases, and especially those with fractures, the patient may have to wear a cervical brace for several weeks before wearing the collar. As soon as there has been sufficient improvement so that exercises can be instituted without increasing pain, neck support should be removed for short periods each day and the length of time gradually increased until the supports can finally be discarded. Lumbosacral corset supports are applied to those patients with severe low back complaints. Some form of traction apparatus should be set up in the home, either on the bed or suspended from an overhead position, so that the patient can use it intermittently throughout the day. Many patients prefer to sleep in traction for some time after leaving the hospital. A cervical pillow affords a more restful support for the neck.

Office physiotherapy may consist of one or more of the following: hot wet packs, diathermy, ultrasonic therapy, massage by hand or by one of the electronic muscle stimulation machines. Traction in the office is best administered by an intermittent motorized traction machine which can deliver up to 40 pounds pull on the head without becoming intolerable. Localized trigger points of muscle tenderness can be injected with Novocain. All of these measures are not carried

Fig. 4. — Roentgenogram showing the S-shaped curve present when the patient holds the head as erect as possible without increasing pain.

out simultaneously, but it is well to have a good armamentarium of treatment. If the patient is not improving rapidly enough for his satisfaction, he will not become so easily discouraged if he knows that his doctor can offer him another type of treatment that might get the desired results. If his doctor has nothing new to offer, then he will soon drift to another one or to a chiropractor.

Antispasmodic drugs are given orally although it is believed that none of the mephenesin drugs are nearly so effective by this route as when given intravenously. Analgesics, with narcotics when necessary, and sedatives must be given as required to control pain, nervousness and sleeplessness. In recent months the use of Miltown or Equanil has seemed to give good results in relieving anxiety and nervousness as well as having some effect on muscle spasm.

A most important part of the treatment of the patient as a whole is the consideration of the mental factor. The victim of a severe whiplash injury frequently has periods of emotional upset, and when the disability becomes prolonged, he is easily discouraged and depressed. It is in the treatment of the patient in this category that the family doctor plays an outstanding role, even though the patient may be under the active treatment of an orthopedist or a neurosurgeon. His condition must be explained to him in terms that he can understand. In order to keep him from being too discouraged when he finds that he has not recovered at the end of five or six weeks' time, he must be told from the beginning that it is not too unusual for his type of injury to require a long period of recovery. At the same time, in order to prevent him from becoming despondent about his future, he must constantly be given encouragement and reassured that in time he will improve. Any doctor who has treated many patients of this type has no doubt had experiences of being called at all hours of the day or night by a sobbing or near hysterical person who "just can't stand these pains and headaches any longer." A few moments of calm reassurance on the phone can usually persuade them to carry on a little longer.

Medicolegal Considerations

Since the majority of whiplash injuries are caused by automobile accidents, the legal aspects call for special consideration. Within a short time of the accident, the treating physician can expect to receive a request for a report to his patient's attorney and/or an insurance adjuster for a diagnosis and prognosis. After about two weeks it is usually possible for the doctor to have some idea of the prognosis even though it may be just a rough estimate. Within that time I try to classify the injury into one of three groups, namely:

1. The mild injuries, which require from one to six months to reach maximum recovery, and nearly all of which result in complete recovery.

2. The moderate injuries, which require from six to nine months to reach maximum recovery, and about half of which result in some degree of permanent disability.

3. The severe injuries, which require from 12 to 18 months to reach maximum recovery, and the majority of which have some degree of permanent disability.

In some of the severe injuries there may be some permanent restriction of motion of the spine or some neurologic changes that may be considered objective. For the most part, however, the disability rating must be based on subjective complaints, and therefore one must rely to a great degree on the honesty and integrity of the patient. The doctor who has known the patient before the accident and has had an opportunity to follow his progress subsequent to the injury is in a better position to express an opinion on this aspect than is the one who may be appointed by the court for a single examination. Realizing that an expected monetary gain may be the basis of many complaints, which would disappear after a court settlement, I sent questionnaires to 36 patients with predicted permanent disability who had been discharged after maximum recovery and financial settlements made. Of those who answered, all but one still had complaints similar to ones they had at the time of discharge.

The most common permanent complaints are a constant feeling of soreness and tightness of the neck and/or back, with increased pain caused by sudden twisting or jarring of the body or by remaining in one position for any length of time. Headaches and visual disturbances may be intermittent. The amount of disability depends much upon the occupation of the individual patient. For instance, one who is required to do much overhead work necessitating hyperextension of the neck, as in plastering or painting, may have a serious occupational disability; whereas an executive with the same severity of injury may have only occasional periods of discomfort without causing any loss of income-producing ability.

Summary

Whiplash injuries, although primarily damaging soft tissues in the cervical region, may also traumatize the lower part of the back and damage bone structures and intervertebral disks as well. Early adequate treatment reduces the extent of disability. It is the obligation of every doctor who has examined or treated a victim of whiplash injury to render an honest opinion in regard to the extent of any permanent disability so that a financial settlement can be reached which will be fair both to the patient and to the insurance company involved.

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Discussion

Dr. Jack W. Barrett, Miami: I want to thank Dr. Russell for asking me to comment on what I consider a most excellent review of this subject. In the way of emphasizing some of the points that he made, I think that certainly we do not want to judge the severity of a whiplash injury to the neck, for instance, on the basis of damage done to the automobile. It stands to reason, however, that the amount of damage to the vehicle in dollars and cents may be some index of the force of the impact, which certainly has some bearing on prognosis and treatment of the injury. In roughly the same period of time as covered by Dr. Russell's paper, which is a review of cases over about three years and some 150 in number, I have been cognizant of the fact that in my practice I, too, did not see surgical protruded intervertebral cervical disks. Most authors say that they have observed these surgical disk lesions rarely. Dr. Russell apparently has not seen a surgical cervical disk protrusion, and neither has Dr. Jackson of Dallas, who has a rather large series, although she says that they do occur, but rarely.

I think the comment on the roentgenograms of the cervical spine is something that we should all consider. Too many times our radiologic friends diagnose spasm and straightening of the spine from three films, an anteroposterior, a lateral, and an odontoid view. I believe that number is grossly inadequate to make a statement as to muscle spasm and straightening of the spine. I am speaking now of the cervical spine as regards alleged trauma and accidents. There should be at least three views taken laterally, the neutral lateral, flexion lateral and hyperextension lateral, together with the odontoid view, the anteroposterior view and, in many instances, oblique views before inference should be made as to the spasm and straightening. I also think it is important, as Dr. Russell stated, that the x-ray test be performed by the treating physician, or, if not the treating physician, which is sometimes most impractical, at least by a radiologist who is cognizant of your problem and with whom you have spoken before the roentgenograms are made. If you are interested in the mobility of the spine, before such information can be gained from the roentgenograms, certainly you have to know how they were taken, which is something that cannot be relegated to a technician. Before comments are made on spasm and tightening as evidenced by roentgenograms of the cervical spine, careful consideration should be given to these factors and sufficient roentgenograms are a must.

Dr. Frank O'Connell of Kingsport, Tenn., at one of the recent meetings of the neurosurgeons had a most interesting study. I will not go into detail concerning his study. It will suffice to say that 100 hospitalized patients with complaints not related to the neck, such as gallbladder disease and heart trouble, were subjected as a routine procedure to roentgen examination of the cervical spine. Roughly 70 per cent of the roentgenograms demonstrated abnormalities of the cervical spine, such as narrowing of the interspaces, osteoarthritic overgrowth, subluxation, and other deviations of a minor nature. He observed that the incidence of these abnormalities increased with age. So, again, I think we should be cautious in interpreting these changes on roentgenograms of the cervical spine following an accident. Certainly it is more common to have these changes in the cervical spine without an accident and without their being due to an accident. It would be most helpful, although impossible, if we only knew what the roentgen examination of the cervical spine was prior to the injury.

As to treatment, I would like to mention my pet peeve. I am sure that I will be taken to task for this statement. I think, however, that we are all guilty in that we put braces and collars on patients for spinal injuries too quickly and keep them in these contraptions too long. Each case has to be individualized; but if you decide that a collar or brace is necessary, it seems to me that the patient should use that collar for maybe the duration of the acute or subacute period. All too often we see patients coming in after nine or 10 months, or even a year or a year and a half, still wearing their collars. I believe that after that length of time those poor old muscles are starting to atrophy and we are further weakening the injured musculature. A brace or collar should be worn for a limited period. I am not in a position to say how long, but a few months may be all right, and a lesser time seems advisable. The other big factor about the collar that should be stressed is that too many times it is used to treat the emotional or mental aspect of this illness. When the patient is given a collar, it becomes a sign for the whole world to see indicating that the patient is suffering and has suffered. Under these circumstances, it becomes most difficult to wean the patient away from the collar.

Dr. George T. F. Rahilly, Fort Lauderdale: I wish to extend my thanks to Dr. Russell for the opportunity to review his paper well in advance of this meeting and also to discuss it.

I agree in great part with Dr. Russell's findings and comments and think his paper is a fine one. My only points of disagreement are as follows:

Dr. Russell states that the amount of damage to the automobile is not a particularly significant index of the trauma inflicted. I think it is reasonable to believe that minor accidents are almost invariably going to result in injuries in which a total recovery can be expected. On the other hand, major accidents in the presence of subjective complaints, even without many objective findings, are likewise productive of more severe injuries. This is reasonable, and these complaints should not be dismissed lightly.

I would like to agree at this point with one finding of Dr. Russell which I think needs emphasizing. The fact that people are not aware that they are about to be struck results in more damage to them than to those who are aware that an accident is coming. It is found that the greatest complaints by far are of those in the car that was struck rather than of those who were in the car which did the striking and were probably braced for the accident. In other words, the story that relaxed intoxicated persons never get hurt is not necessarily true, and relaxation is more of a prerequisite to a whiplash injury than bracing by voluntary muscular control.

It is my opinion that more of the pain caused in the chronic cases is due to nerve injury rather than to scar tissue in the capsule and muscle. Most scar tissue is painless, as we know from the severe injuries we see in limbs which do not usually result in painful extremities. The neck should be no exception. The pain is due to damage to the nerves themselves secondary to the actual bruise and hemorrhage in the nerves. Stiffness and scar-

ring in fascial, capsular, and muscle tissue resulting from these accidents, in the absence of previous osteoarthritis, can usually be worked out by good physical therapists as scar tissue usually can gradually be stretched.

I am inclined to think that there is a higher incidence of cervical disk protrusions than Dr. Russell found in his series. More cervical myelography would bear out this point.

Much of the damage done by these injuries, particularly in the low back, simply aggravates pre-existing asymptomatic disk degeneration, and these accidents are frequently the straw that breaks the camel's back. As we all know, over the age of 30, our intervertebral disks in the low back are degenerating spontaneously, and it does not take much to make them become troublesome.

Concerning x-ray evidence of subluxation in the cervical spine, the appearance of apparent anterior subluxation of one cervical vertebral body on the other is frequently physiologic and should not be emphasized too much to the patient or to his attorney. Many uninjured cervical spines in flexion x-rays show what appears to be pronounced anterior subluxation which is physiologic.

Concerning cervical collars and braces, I try to avoid their use because they tend to give the patient the idea that he has a terrible problem and that usually leads to increased desires for high financial awards and more anxiety neurosis. It likewise tends to limit the range of motion in the neck and allows scar tissue to tighten up which might, on the other hand, have remained looser if allowed a greater range of motion. I personally like to keep the patient moving his joints as much as is possible within reason during the recovery period to lessen ultimate limitation of motion.

In my opinion, permanent disability in these injuries is the exception. What damage there is usually consists of injury to nerve roots by disk or bony pressures, and the services of surgery to divide the second cervical nerve to lessen occipital neuralgia may be required. I have seen a few patients who had evidences of relatively intractable occipital neuralgia after one of these injuries who could be helped relatively simply by the technic that has been devised by Dr. Mayfield and reported at the last meeting of the Committee on Trauma of the American College of Surgeons.

Finally, I want to reiterate that I agree with most of Dr. Russell's report, which is comprehensive and instructive. By all means, get these patients under immediate and sympathetic treatment and do not tell them nothing can be done because much can be done to save them and yourself many a headache.

DR. RUSSELL, closing: I wish to thank Dr. Barrett and Dr. Rahilly for their kind words. I am sure we are not too far apart in our thinking. As far as the question of damage to the automobile is concerned, the reason I brought that fact up is that I have frequently had this happen to me. An attorney in attempting to get a higher rating will tell me: "This man's car has had $600 worth of damage. Surely he must be very badly injured." Often it happens that the man was not too badly injured at all. On the other hand, I have had insurance adjusters say: "This man had only $10 worth of damage to his car. How can he have any permanent injury?" It still can be possible. It is true though that in the majority of cases the harder the impact the greater the injury will be.

As far as braces and collars are concerned — I rarely use braces, but frequently use collars on the severely injured during the first few weeks or months — I, too, agree that they can be relied upon too greatly. On the other hand, I think that these patients are spared much needless suffering during the first few weeks if they are given that support. I do agree, however, that it is necessary to try to wean them away from it just as soon as possible and get them exercising even during the period they are wearing it part time, or have them remove it for periods for neck exercises.

As far as the cervical disk problem is concerned, perhaps we do not do enough cervical myelography, but I do agree with the writings of Dr. Jackson that the anatomy in the cervical region differs greatly from that in the lumbar region. I think that the cervical disks are relatively few, although it is possible we do miss some by not obtaining the cervical myelogram.

Nonpenetrating Abdominal Trauma

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Nonpenetrating abdominal trauma is often the most dramatic of surgical emergencies. At the same time, such injuries may be the most difficult of diagnostic problems. The finest clinical judgment of which the surgeon is capable must be exercised in the management of such cases. Unfortunately, closed abdominal trauma as the sole injury in a patient is the exception rather than the rule. Frequently, one's diagnostic acumen is taxed by the masking features of a concomitant wound of the head, chest or extremity. All too often, one's attention is diverted from the possibility of a closed abdominal wound, which subsequently contributes to the demise of the patient, because of the obvious head injury, crushed thorax, or fractured femur absorbing attention. All injured patients must be examined in an orderly fashion covering every region of the body. One must keep in mind a classification of the types of closed abdominal injury and examine each patient, no matter how trivial his injury, with that classification as a mental guide in diagnosis.

In rather broad but workable terms, there are three major categories of nonpenetrating abdominal trauma. Such injuries can give rise to clinical signs and symptoms associated with

I. Hemorrhage
II. Peritonitis
III. Neither hemorrhage nor peritonitis

Using this classification, one may list closed abdominal injuries producing trauma to or rupture of abdominal viscera as shown in table 1.

There are a few special points one must keep in mind in regard to both hemorrhage and peritonitis as they pertain to intra-abdominal injury.

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Read before the Florida Medical Association, Eighty-Second Annual Meeting, Miami Beach, May 15, 1956.

Table 1.—Classification of Closed Abdominal Injuries

I. Hemorrhage as Principal Manifestation
  1. Spleen
  2. Liver
  3. Kidney
  4. Pancreas
  5. Major blood vessels
  6. Retroperitoneal and preperitoneal hematoma associated with fracture of spine or pelvis

I. Peritonitis as Principal Manifestation
  1. Rupture of stomach
  2. Rupture of small or large intestine
  3. Rupture of retroperitoneal duodenum
  4. Rupture of urinary bladder
  5. Bile ducts, gallbladder and occasionally liver

III. Neither Peritonitis nor Hemorrage
  1. Rupture of diaphragm

Hemorrhage may occur rapidly and progress steadily to exsanguination. Here, of course, it is accompanied by all the classical manifestations of shock. Much more frequently, after an initial hemorrhage, clotting may occur, and the patient becomes temporarily stabilized with a relatively normal blood pressure, hemoglobin and vital signs. Subsequently, bleeding recurs, and if the diagnosis has not been made prior to this recurrence, the patient may well be lost. There is apparently a popular misconception that blood free in the peritoneal cavity causes hypoperistalsis or an adynamic ileus. This concept as far as it pertains to the reaction to intraperitoneal blood for the first 24 hours is wrong. Free blood, initially, acts as a stimulant to peristalsis. Hyperperistalsis as determined by auscultation is the rule rather than the exception.

In cases of ruptured spleen, uncomplicated by concomitant perforation of the bowel or stomach leading to peritonitis, I have yet to find peristalsis absent in the early stages. Hemorrhage into the peritoneal cavity, as well as severe hemorrhage into the thorax, retroperitoneal or preperitoneal areas, or massive hemorrhage into the thigh tissues with a fractured femur, causes an almost immediate rise in the white blood cell count to 14,000 or above. Often the initial laboratory examination of the blood in intra-abdominal hemorrhage will show a normal hemoglobin content and hematocrit reading, but the white blood cell count will be elevated. Only over a period time, possibly hours, will there be a drop in the hemoglobin content and hematocrit reading. Blood in the peritoneal cavity may give some manifestation of peritoneal irritation, but tenderness and spasm often are minimal. This response may well be due to the location of the blood. If it is trapped between coils of intestines or lies pooled high under the rib margin, there may be little irritation to the peritoneum of the anterior abdominal wall. Referred pain and tenderness to the shoulder region with hepatic and splenic injuries may or may not be present depending, again, upon whether or not blood is so located that it can cause irritation of the diaphragm with reflex pain referral. On occasion, I have seen ruptured spleens with massive intra-abdominal hemorrhage fail to demonstrate this phenomenon and subsequently observed its development after the patient was placed in mild Trendelenburg position, allowing blood to gravitate upward against the diaphragm. It may occasionally be produced by applying strong pressure over the left hypochondrium.

Peritonitis associated with a ruptured viscus may not appear initially. Once it is present, of course, the classical signs of tenderness, spasm, rigidity and adynamic ileus become manifest. There are several reasons why there may be a delay in signs from a perforated viscus:

1. The masking effect of shock
2. The masking effect of associated head or chest injuries
3. Temporary spasm of the bowel preventing leakage
4. Temporary omental seal

One must keep in mind the fact that there is a lag period between the contamination of the peritoneal cavity and the onset of peritonitis. This is especially true if noninfected bile is spilled. It is, however, also true with perforation of the bowel. One needs but to recall cases of appendicitis in which the appendix ruptured while the patient was en route to the hospital. Whereas previously there was pain, tenderness, and spasm, for a little while following the rupture the patient is painfree, and the abdominal examination gives negative results. The same sequence of events can and does occur on occasion with traumatic perforations.

Keeping in mind the points mentioned as regards hemorrhage and peritonitis, how does one go about establishing the diagnosis of an intra-abdominal injury? One must preface this phase of the discussion by stating emphatically that the diagnosis of closed abdominal injuries can rarely be made on a single diagnostic examination. Meticulous observation and repeated examinations made at frequent intervals offer the only certain method of proper diagnosis. In the examination of an injured patient one must follow an orderly plan of attack (table 2).

Table 2.—Steps in Diagnosis of Abdominal Injury

I. History
II. Physical Examination
III. Laboratory Studies
  1. Catheterized urinalysis
  2. Hemoglobin estimation, hematocrit reading and white blood cell count
  3. Blood typing and cross match
  4. Serum amylase
IV. Radiographic Studies
  1. Two or three position radiographs of the abdomen
  2. Intravenous pyelogram
  3. Cystogram (?)
V. Special Tests
  1. Abdominal tap(?)

I. History

Often a history is unobtainable, but if one can be obtained, the manner and type of injury may give valuable information. Rapid deceleration associated with automobile accidents or falling from some height is often associated with tears of the spleen and liver. A blow over the lower part of the thorax on the left side may cause splenic rupture. Crushing injuries such as occur when a patient is run over by an automobile or truck make one suspicious of perforation of a hollow viscus as well as splenic, renal or hepatic injury. A blow over the lower part of the abdomen in a patient who has been drinking may well cause perforation of a full bladder.

II. Physical Examination

1. Inspection.—On inspection, contusions of the wall of the abdomen or lower part of the chest may arouse suspicion. Bruises over the lower posterior portion of the chest are often a clue to the possibility of splenic rupture.

2. Percussion.—Areas of abnormal gas shadows may be delineated on percussion, such as the obliteration of the usual area of liver dullness by an accumulation of air under the diaphragm from a ruptured stomach. Shifting dullness due to free blood in the peritoneal cavity may occasionally be elicited.

3. Palpation.—On palpation, a localized area of tenderness, rigidity or spasm may be delineated. One must remember that fractured ribs may cause tenderness and some rigidity in the associated upper abdominal quadrant. Frequently a fractured femur will cause tenderness and some rigidity in both the upper and lower abdominal quadrant of the affected side. Local nerve block may be of help in differentiating between the findings in the local abdominal wall due to the fractured ribs and those due to some intra-abdominal lesion. Re-examination of a patient with a fractured femur subsequent to splinting and traction of the extremity may be of considerable help in differential diagnosis.

4. Auscultation.—The presence or absence of peristalsis must always be noted; it serves as a base line for subsequent examination. As mentioned previously, absence of peristalsis suggests peritoneal contamination from a ruptured hollow viscus or a hematoma in the mesenteric root, whereas normal peristalsis or hyperperistalsis is frequently present with free intraperitoneal hemorrhage.

5. Shock.—The presence or absence of shock must be determined. This requires blood pressure, pulse and respiration determinations at 15 minute or half hour intervals. Two points are worthy of particular mention. Head injuries, except in the terminal stages, affect the vital signs in a manner directly opposite to the findings manifested in shock. With a head injury and increasing intracranial pressure the blood pressure rises, and the pulse slows down. All too often shock in an injured patient who has a head injury has been erroneously ascribed to that injury. It is of utmost importance to follow the rule that if a patient has a head injury and is in shock, one is obligated to find some other cause of the shock. Most frequently, the cause is intra-abdominal or intrathoracic hemorrhage.

The other factor to keep in mind in regard to shock is that blood loss, instead of giving an apathetic, listless state, is often associated with restlessness and hyperactivity. A restless, hyperactive injured patient with alcohol on his breath may not be intoxicated; he may be in impending shock from hemorrhage.

III. Laboratory Studies

1. Catheterized Urinalysis.—The volume of urine, or lack thereof, may give an indication of a perforation of the bladder. One can rule this possibility in or out by completely emptying the bladder and instilling a measured amount (200 ml.) of sterile physiologic saline and then withdrawing it. If less than the amount instilled is obtained, the possibility of a ruptured bladder is very real. This can be checked by a cystogram when the patient is being subjected to radiographic examination. Pelvic or lower abdominal trauma requires a cystogram. Gross blood in the urine, or microscopic evidence of red cells, suggests injury to the kidney or bladder.

2. Hemoglobin Determination, Hematocrit Reading and White Blood Cell Count.—

The importance of the white blood cell count has been discussed previously. The hemoglobin and hematocrit determinations should be repeated frequently since the initial readings may be normal but become abnormal as bleeding continues or as delayed hemorrhage occurs.

3. Blood Typing and Cross Match.—If a closed abdominal injury is present, whole blood will be needed and may be needed urgently even though on the initial examination the patient appears in good condition.

4. Serum Amylase.—Repeated determinations may delineate pancreatic injury which cannot be established readily in any other manner.

IV. Radiographic Studies

1. Abdominal Radiographs.—While radiographs taken in three positions are desirable, it may be impossible to obtain a radiograph with the patient in the upright position to demonstrate fluid levels in the abdomen or free air, from a perforated viscus, under the leaf of the diaphragm. Radiographs taken in two positions, however, one with the patient in the supine position and the other with the patient in the right lateral decubitus position, can be obtained in most instances and may give sufficient information. The radiographic findings most commonly associated with ruptured spleen are enumerated in table 3.

Table 3.—Radiographic Findings Suggestive of Splenic Injury

1. Elevation of left hemidiaphragm
2. Pleural effusion (left)
3. Obliteration of splenic shadow
4. Increased density of shadow under left diaphragmatic dome
5. Progressively larger splenic shadow by serial studies
6. Serration of margin of greater curvature of stomach
7. Compression of stomach fundus
8. Downward displacement of cardiac end of stomach
9. Downward displacement of splenic flexure of colon
10. Psoas shadow obscured

2. Intravenous Pyelography.—While the patient is on the x-ray table, it is a simple matter to accomplish excretory urography. Failure of visualization of one kidney or extravasation of the dye into the perirenal area may indicate a lacerated kidney.

V. Special Diagnostic Tests

1. Abdominal Tap.—While many endorse an abdominal tap as a reliable test for determination of free blood in the peritoneal cavity, I have not employed it. In most cases, the diagnosis can be made without such a test. Although it apparently has caused no complication in the hands of those utilizing the method, I am not enthusiastic about the blind insertion of a needle into a cavity filled with intestinal loops. It has been my experience that in those cases in which there is only moderate bleeding, when one first enters the abdomen, no blood may be seen until the intestinal loops are disturbed and the blood pooled between the mesentery leaves is released. Finally, while an abdominal aspiration giving positive evidence is helpful, a negative result does not rule out the presence of free blood. A series of 10 such aspirations was carried out on the staff service of the Jackson Memorial Hospital on patients in whom the diagnosis of intra-abdominal hemorrhage had been made and who were to be subjected to an exploratory operation. In nine of the cases aspiration yielded blood. In one case the aspiration gave a negative result although subsequent exploration showed a considerable quantity of blood to be present.

Management of Intra-Abdominal Trauma

As I have mentioned previously, a high index of suspicion in regard to the presence of abdominal injury must be maintained in all cases of injury. Repeated examination of the patient and repeated laboratory tests must be accomplished frequently for a period of several hours. Even after a 12 hour period one must keep in mind that delayed hemorrhage, that is, hemorrhage occurring 48 hours after the initial injury with a definite latent period between bleeding episodes, occurs relatively frequently in splenic injuries.

If shock is present, it must be treated vigorously with whole blood. Plasma and dextran may be used initially until blood is obtained. While it is an accepted surgical principle not to start anesthesia or an operation while a patient is in shock, this principle is not applicable if the shock is due to active hemorrhage. In some instances it may be necessary to institute shock therapy and proceed immediately with an exploratory celiotomy.

A nasogastric tube should be inserted and the stomach evacuated early in the course of management. Gastric dilatation usually accompanies all severe injuries. The presence of this distention not only confuses the abdominal findings, giving pain and tenderness, but it is a real source of danger to the patient since regurgitation and aspiration often ensue.

Exploratory celiotomy is indicated in all cases in which the diagnosis of intra-abdominal injury is established or strongly suspected. An exploration

giving negative evidence is far better than a missed diagnosis. Often the decision to explore an abdomen is made more difficult because the patient has other severe trauma such as a head injury or a crushed chest. As a general rule, if definite intra-abdominal trauma is present, then abdominal exploration must be carried out, or the patient will die. The most difficult decision rests with those cases in which the patient has other extensive injuries and the diagnosis of intra-abdominal trauma is not clearcut. If the patient can be gotten into reasonable shape, it is my opinion that exploratory celiotomy should be carried out. If an unrecognized abdominal injury is present, it may tip the balance against the severely injured patient. As the patient's condition deteriorates, the abdominal injury may become more manifest, and at that point the patient may not withstand any procedure. It has been my experience that even the patient with severe head injuries tolerates abdominal exploration surprisingly well. While my exploratory operations giving negative results have been relatively few, those few patients with severe head injuries and a negative result from celiotomy, accomplished early in their hospital course, have progressed entirely satisfactorily. The same holds true for severe chest injuries. If one has a competent anesthesiologist well versed in endotracheal technics and with an adequate knowledge of respiratory physiology, in such cases the patient can tolerate an early abdominal exploration before the period when multiple chest complications have set in.

Several points are worth mentioning in regard to operative technic. The incision must be generous, permitting the introduction of both hands into the abdomen. Most surgeons prefer a vertical incision although with a definite diagnosis of upper abdominal injury, I often employ a transverse incision. The reason for this choice, especially with a preoperative diagnosis of a ruptured spleen, is that it gives access more readily to handling associated liver injuries. It is a more time-consuming incision to make and should not be used when active bleeding is occurring or in cases in which the diagnosis is doubtful.

With the relaxation associated with anesthesia and the sudden release of intra-abdominal pressure attendant on the opening of the peritoneum, one must be prepared for the occurrence of sudden massive hemorrhage. A venoclysis, preferably with blood already started, should be running prior to incising the peritoneum. Upon incision, the surgeon must be ready to compress immediately, with his hand, the splenic artery against the superior surface of the pancreas, the hepatic artery through the foramen of Winslow, or the aorta itself if necessary.

Care must be exercised in clamping and dividing the vasa brevia if the spleen is to be excised. All too frequently, the greater curvature of the stomach is traumatized, and a perforation develops subsequently.

Regardless of the major pathologic changes found, the entire abdomen must be explored. The diaphragms must be checked for rupture and all surfaces of the liver and spleen palpated carefully. The stomach and the entire bowel must be inspected inch by inch. Often it is more accurate and less time-consuming to deliver the entire small bowel out of the abdominal cavity. The large bowel, pancreas, kidney areas and retroperitoneal areas must be thoroughly inspected. The usual sites of injury to the small bowel are the relatively fixed portions: the retroperitoneal duodenum as it passes over the vertebral column, the jejunum near the ligament of Treitz and the terminal portion of the ileum. Suture closure or resection and anastomosis may be indicated in injuries of the small bowel. Perforations of the large bowel may be closed primarily if one also institutes a proximal colostomy. Exteriorization or resection and anastomosis with proximal colostomy may be indicated in some instances.

In injuries to the liver, drains should always be inserted through the abdominal wall regardless of the adequacy of the mattress suture closure.

Summary

A classification of closed abdominal injuries is presented.

Emphasis is placed on meticulous and frequent observation of the patient in order to delineate the diagnosis.

Early exploration is advocated for all suspected abdominal injuries, even if there are other severe injuries present.

Major points in the diagnosis and management of such injuries are discussed.

Jackson Memorial Hospital.

Blood Vessel Replacement Therapy

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For centuries men have entertained the thought of replacing diseased or worn out parts of the human body. Tissue grafting was discussed in the manuscripts of the ancients, and skin grafting, it has been reported, was attempted as long ago as Babylonian days.

In the latter part of the nineteenth century, as surgical technics and methods improved, the fundamentals of blood vessel surgery began to evolve. In 1899, Dorfler[1] published the essentials of the present day technics of blood vessel suturing, and in 1905 Dr. Charles Guthrie[2] and Alexis Carrel, working in the Hull Physiology Laboratories of the University of Chicago, demonstrated in the experimental animal that blood vessel transplants could be accomplished successfully. Autogenous vein grafts and homologous arterial grafts appeared equally successful in reconstructing arterial channels.

The clinical application of these important contributions, with few outstanding exceptions, was not generally realized until after World War II when, in 1949, Gross, Bill and Peirce[3] published their first article on the use of homologous arterial grafts in the operative correction of coarctation of the aorta. This publication evoked considerable interest throughout the world, and subsequently blood vessel banks were developed in many medical centers.

The use of homologous arterial grafts and autogenous vein grafts in the therapy of traumatic aneurysm and arteriovenous fistula proved to be highly successful in Korean war wounded.[4] As more experience was gained, the scope of blood vessel replacement therapy increased. The degenerative arterial diseases resulting in either aneurysmal dilatation or thrombotic occlusion appear to be on the increase as the life span of man is extended. Although it has long been recognized that arteriosclerosis is a systemic disease with widespread involvement of the arterial system, obliterative arterial changes and aneurysmal dilatation in many instances are segmental in nature and therefore may be amenable to surgical therapy. Armed with these concepts concerning the degenerative arterial diseases, the vascular surgeon today has opened before him a vast new field of blood vessel surgery.[5-8]

This report is based on experience with 46 operations in which blood vessel transplants of one type or another were used to reconstruct arterial continuity. Table 1 shows the total number of transplants divided into the significant anatomic regions. The earliest graft in this series was placed in the thoracic aorta in 1950 for the correction of coarctation. In table 2 is listed the operative mortality of the entire groups. Emergency operative procedures performed on aneurysms that had ruptured are listed first. One of the fatalities in this group occurred 16 days postoperatively because of renal failure which was preceded by jaundice (total serum bilirubin 24 mg.), the cause of which was not determined although transfusion reaction was suspected and thoroughly investigated. Generally speaking, these are extremely difficult cases to treat for many obvious reasons. The solution to such problems, of course, is to find the aneurysm and to remove it before serious complications can occur. It is well recognized at the present time that the course of an aneurysm cannot be predicted with any degree of certainty, and that in the majority, perhaps three fourths, of such cases serious and frequently fatal complications will develop within three years from the time the aneurysm is recognized.

Table 1.—Vascular Transplants

Abdominal aorta	18
Subclavian, axilliary, brachial	6
Thoracic aorta and arch	6
Iliac, common femoral	6
Superficial femoral, popliteal	10
Total	46

Table 2.—Mortality

	Operations	Deaths
Ruptured aneurysm operated as emergency	4*	2
Abdominal aorta	16	2
Thoracic aorta and arch	5	3
Peripheral vessels	22	2
Total	47	9 (19.1%)

*No graft used in first operation, one case.

Abdominal Aortic Grafts

Sixteen grafts were placed in the abdominal aorta as elective procedures (fig. 1 ab). In all

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Read before the Third Latin American Congress of Angiology, Havana, Cuba, November 1956.

Figure 1

a. A typical arteriosclerotic aneurysm of the abdominal aorta arising below the renal arteries and extending to involve the aortic bifurcation.

b. Homologous arterial Y graft in place after excision of the aneurysm. Note the left renal vein just above the proximal suture line.

instances operation was carried out through a midline abdominal incision from the xiphoid process to the pubic bone. On two occasions the aneurysm was so large that a separate thoracotomy incision through the fifth intercostal space was performed, and control of the aorta above the diaphragm by finger compression facilitated dissection within the abdomen. Vessel suturing was accomplished with 0000 arterial silk and either a continuous everting mattress or simple over and over stitch (fig. 2). The everting mattress suture is advantageous when there is great disproportion between the host vessel and the transplant. End to end anastomosis is usually performed between the proximal aorta and the transplant; however, end to side anastomosis between the transplant and distal vessels is frequently found to be a most valuable method.

Two of the patients in this group died in the early postoperative period; both had severe obliterative vascular disease distal to the abdominal aneurysm. In both cases the internal iliac arteries were completely occluded, and despite the fact that good femoral pulses were obtained in each instance, adequate blood flow to the buttocks and perineum was not established, and death soon followed. It is presumed that circulation to the buttocks and perineum had been maintained by lumbar arteries arising from the aneurysm, and these, of course, were destroyed with excision of the aneurysm. Gluteal claudication was an important symptom in the history of each of these patients, indicating severe occlusive disease of the internal iliac artery.

Thoracic Aorta

In the thoracic aorta group there were six operations and three deaths. My associates and I have not had the fortune to see a large number of syphilitic aneurysms, which are more prone to occur in the thorax than elsewhere, and only one of these operations was performed for a syphilitic aneurysm which involved the distal aortic arch. Figure 3 shows the aneurysm which was excised and vascular continuity re-established by a homologous arterial graft, but unfortunately this patient succumbed in the early postoperative period. Figure 4 shows another thoracic aneurysm involving the descending aorta. This aneurysm ruptured, and at emergency thoracotomy it was

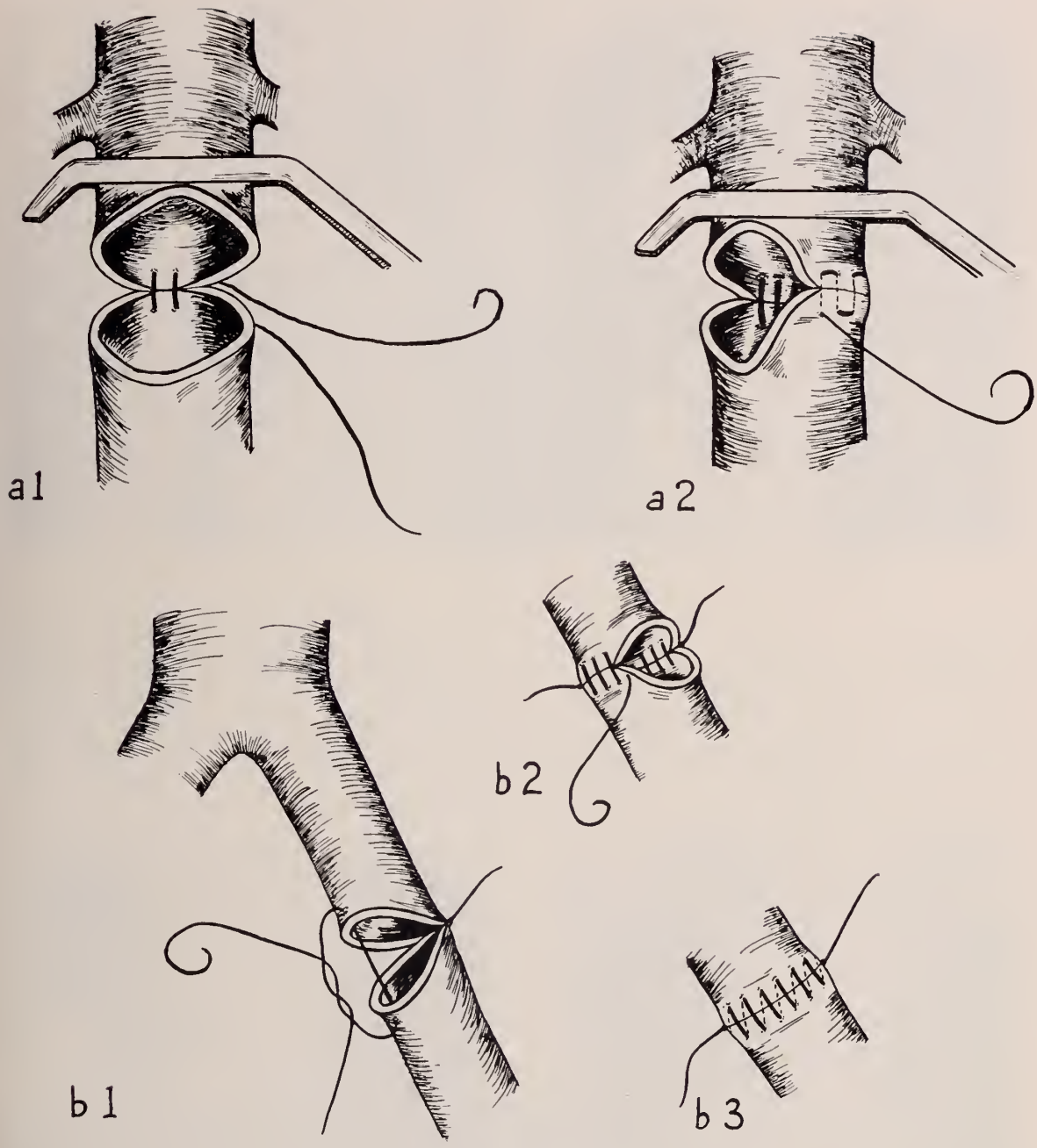

Figure 2. — Types of Suture

a 1. Homologous arterial graft is sutured to the proximal aorta using an everting mattress stitch.
b 1, 2, 3. The over and over suture has the advantage of ease of placement and is used except when there is disproportion between the vessels or the proximal aorta is badly diseased.

possible to control the hemorrhage. Definitive surgery was performed later at a more opportune time with highly satisfactory results. The roentgenogram on the left was taken after the aneurysm had been excised.

In each of these two instances hypothermia was used to protect the viscera distal to the aneurysm. As an additional safeguard, Tygon tubing (fig. 5) was threaded through the graft and placed in the lumen of the proximal and distal vessels so that blood flow was interrupted only for short intervals. Johnson, Kirby and Lehr[9] published a similar method using a flange on the internal shunt to prevent slipping. Here we have relied on length of tubing to prevent its slipping out of place. This tubing has a 3/8 inch internal diameter, and a good flow of blood through the operative area is obtained. Removing the tube is simple. Before

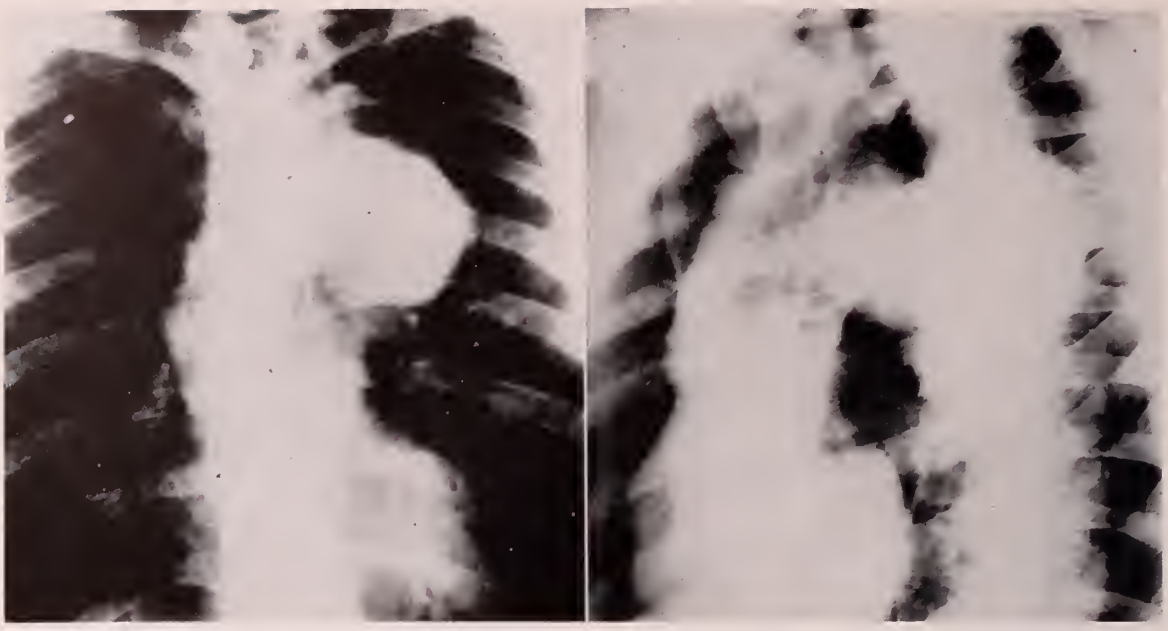

Fig. 3.—Syphilitic aneurysm involving the distal aortic arch.

the last sutures are placed, two hemostats grasp the tubing (fig. 5c), which is then cut between the clamps and the two pieces withdrawn. Thereafter it takes only a few minutes to complete the anastomosis. This method, of course, could not be used in lesions of the ascending or transverse portion of the aortic arch.

Obliterative Arterial Disease

In the obliterative arterial diseases our results have not been as good as with aneurysm.[10,11] The cases in this group are tabulated in table 3. One of the obvious problems in occlusive arterial disease is that the disease is diffuse and that there may be occlusion distal to the by-passed segment.

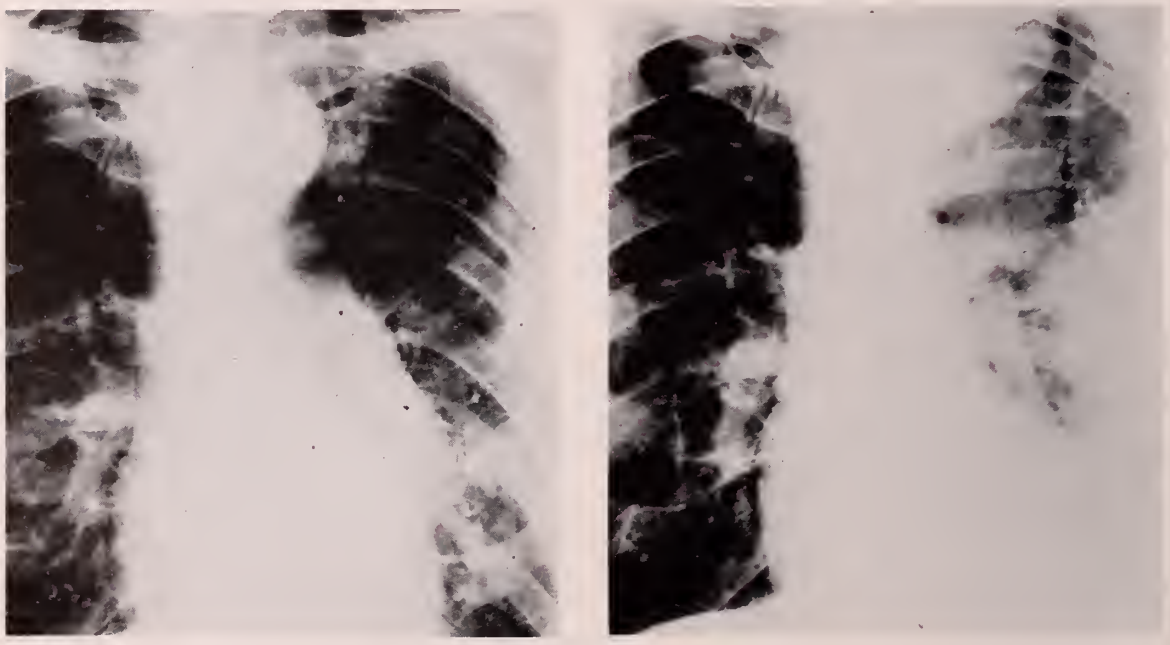

Figure 4

a. Arteriosclerotic aneurysm involving the descending thoracic aorta.

b. Postoperative roentgenogram after excision of the aneurysm.

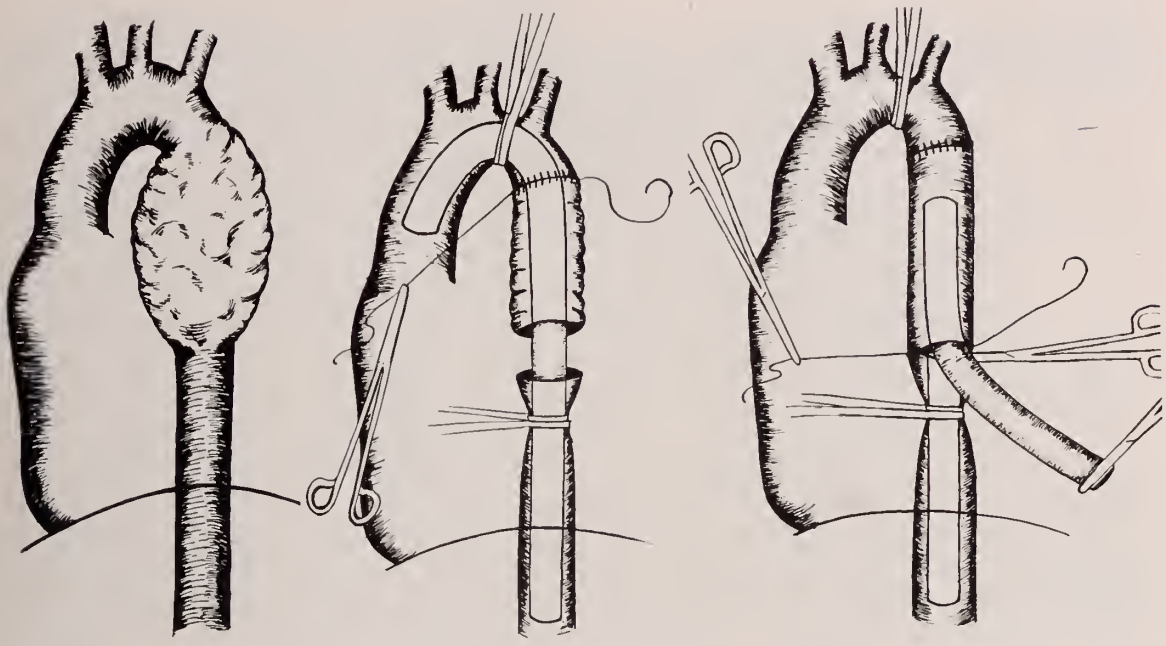

Figure 5. — Plastic tubing used as internal shunt.

In one instance of a common femoral to popliteal artery anastomosis, pulses were vigorous beyond the distal anastomosis, but the foot remained cool and discolored; no pedal pulses could be elicited. This, therefore, was a failure although we could still visualize a functioning by-pass graft. A more careful selection of cases perhaps will eliminate some of these failures; however, surprising results sometimes occur when circumstances would indicate otherwise.

Table 3.—Obliterative Arterial Disease

	Cases	Good	Fair	Poor
Terminal aorta	1	1		
Terminal aorta				
Plus external iliac	1		1*	
Plus femoral	1		1*	
External iliac	3	2		1
Superficial femoral	4	2	1	1
Total	10	5	3	2

*One leg improved.

To demonstrate this point, figure 6 shows the foot of a patient who had an amputation of the fifth toe for gangrene which followed minor trauma. The amputation site had not healed over a period of several months, and there was obviously deep-seated infection secondary to arterial insufficiency. Angiograms demonstrated a segmental block of the superficial femoral artery. A homologous arterial by-pass graft using end to side technic from the superficial femoral to the popliteal artery was constructed in an attempt to increase peripheral blood flow. This by-pass has functioned well (fig. 6b). Figure 6c, taken

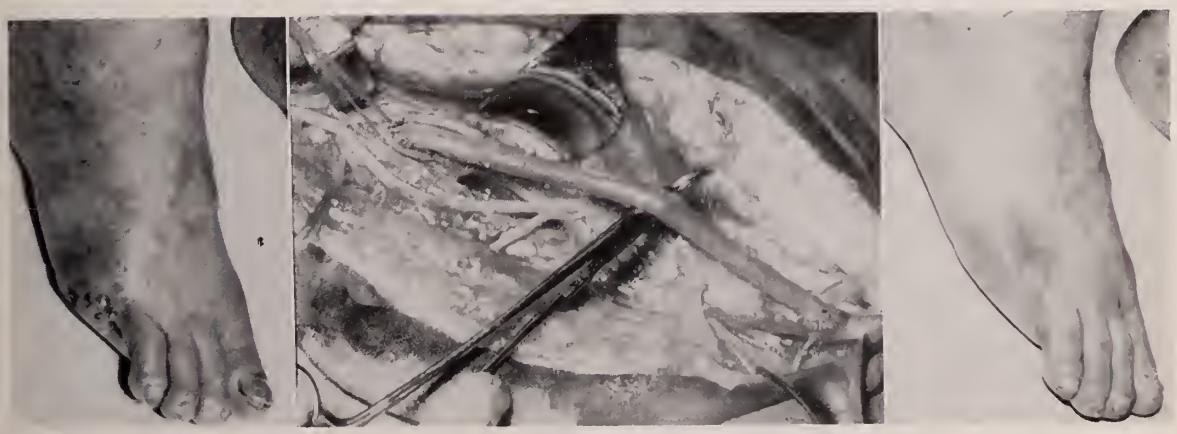

Figure 6.—Femoral Transplant

a. Preoperative. b. Transplant in place. c. Three months postoperatively.

Fig. 7.—Autogenous vein graft in the common femoral artery after excision of an arteriovenous fistula.

several months later, shows a healed amputation site and rather dramatic improvement in the appearance and function of the foot.

Discussion

In the final analysis, of the patients who survived the operation for aneurysm the results have been most gratifying. In all instances peripheral circulation has been adequately re-established. Only two of these patients so far have died in the late postoperative period; one died of prostatic malignant disease and the other of a ruptured abdominal aneurysm after a successful transplant for a thoracic aneurysm. In both instances, autopsy was obtained, and the homologous graft was functioning well at the time of death.

In discussing the cause of failure of peripheral transplants, it should be pointed out that in all cases of traumatic arteriovenous fistula and aneurysm in which transplants were used to reconstruct vascular continuity, the results have been excellent. Of the peripheral transplants in this series, 14 were used for traumatic arteriovenous fistula and aneurysms of war wounded previously alluded to in this paper.[4] In nine of the 14 cases autogenous vein grafts were used and in five homologous arterial grafts. These transplants have functioned in a highly satisfactory manner for many years. Figure 7 demonstrates a vein graft in the common femoral artery which bridges a defect following excision of an arteriovenous fistula between the common femoral artery and vein. This vein graft has been in place now four and one-half years. Figure 8 shows an angiogram of a popliteal vein graft used to bridge a defect in the popliteal artery following excision of a traumatic aneurysm. Although larger than the artery, it has functioned satisfactorily since 1951. Figure 9 demonstrates by angiography a saphenous vein graft in the superficial femoral artery following excision of a traumatic arteriovenous fistula functioning since 1951.

We conclude, therefore, that when normal or near normal proximal and distal arterial segments are present, restoration of vascular continuity can be accomplished with certainty. In obliterative arterial disease, however, our experience would seem to indicate that it is the disease itself with skip areas of obliteration which in most instances determines the success or failure of these methods if they have been properly applied.

The use of plastic materials in blood vessel surgery is receiving much attention in the laboratory, and the clinical use of various plastics is increasing. Although we have used various types of woven cloth prosthesis in the experimental laboratory, we have placed woven plastic material in the human only on two occasions. Once in place, the plastic cloth prosthesis functions well. Suturing plastic cloth, however, in the normal blood vessel of the experimental animal is no trick at all, but placing this inelastic material in the vascular tree of the arteriosclerotic patient with aneurysmal dilatation above and obliterative arterial disease below is an entirely different prob-

Fig. 8. — Angiogram showing a vein graft used to bridge a defect in the popliteal artery.

lem. It is primarily for this reason that this series is largely made up of homologous arterial grafts and autogenous vein grafts. For over two years now our banked grafts have been procured under ordinary autopsy conditions. They are then sterilized with Beta-Propiolactone,[12] quick-frozen and stored in the frozen state at minus 28° to 30° C.[13] Graft procurement appears easier as time goes on, and our graft bank has kept up with demands. Nevertheless, the use of plastics for many obvious reasons has certain advantages, and continued study of this problem is extremely important.

Summary

For short defects in peripheral vessels such as are encountered in traumatic aneurysm or arteriovenous fistula, the autogenous vein graft offers an excellent method of reconstructing vascular continuity.

The homologous arterial graft which has been sterilized and stored in a frozen state has given most satisfactory results in the surgical treatment of aneurysm.

The homologous arterial graft in the treatment of obliterative arterial disease has given satisfactory results, but not as satisfactory as for aneurysm; most of the failures we attribute to the nature of the arteriosclerotic disease itself.

The experimental use of plastic material is continuing.

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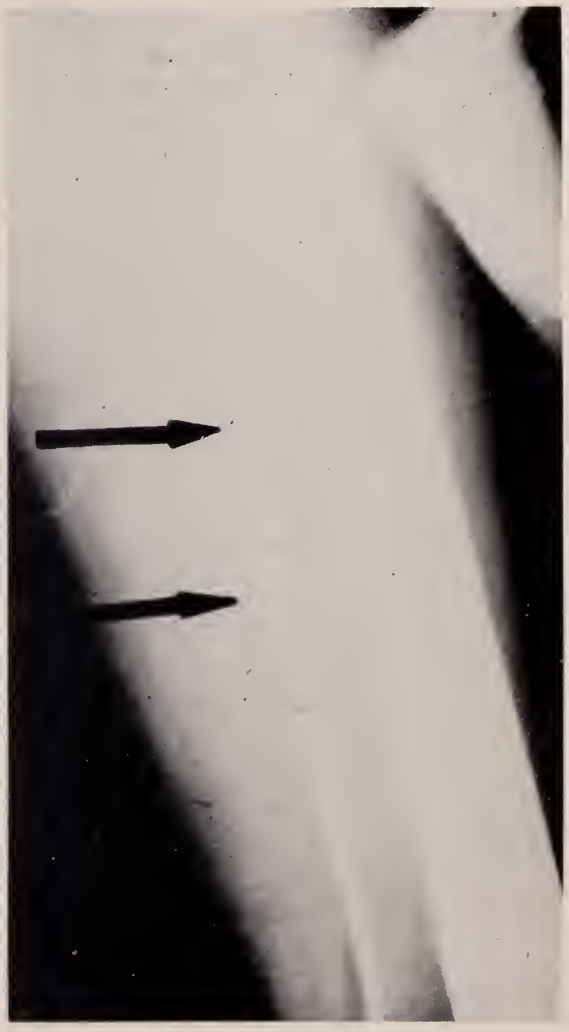

Fig. 9. — A saphenous vein graft demonstrated by angiography in the superficial femoral artery following excision of an arteriovenous fistula.

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Human Allergy Resulting from North American Snake Venoms

Report of Two Cases

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OCALA

Many animal proteins are known which produce allergy in humans. Various animal danders and feathers may produce respiratory allergy or contact dermatitis. Horse serum is an important source of serum sickness and anaphylactic shock in man. Deaths have been reported which resulted from allergy produced by the bites of ants and spiders, and the stings of bees, wasps, and yellow jackets.[1] Some writers have suggested that occasional deaths from snake venom poisoning are due to allergy, but a search of available literature reveals reports of only two cases in which allergy to the venom of North American snakes was confirmed. Zozaya and Stadelman,[2] using scratch tests, demonstrated allergy to snake venom in a man who had been injected with several kinds of venom for experimental purposes and in whom coryza and sneezing later developed when he was working around dried snake venom. Lounsberry[3] reported a case in which anaphylaxis and a generalized dermatitis developed when the patient was bitten by a rattlesnake. He attributed this allergy to a previous snakebite which had rendered the patient hypersensitive to venom. The purpose of this paper is to report two additional cases of hypersensitiveness to the venom of North American poisonous snakes.

Snake venom is a complex substance comprised chiefly of proteins.[4] Kellaway[5] attributed the toxicity of snake venoms primarily to proteolytic enzymes, phosphatidases and neurotoxins. They also contain powerful spreading factors, including hyaluronidase, which promote their spread in the body tissues. Histamine is released when venom is injected into animals or man. Since snake venom is an animal protein, there is the possibility that hypersensitiveness to it may develop.

Report of Cases

CASE 1.—A 34 year old white man, a professional biologist, has worked with poisonous snakes and has received 12 different bites and a number of relatively insignificant scratches from venomous snakes. He has been bitten by seven cottonmouth moccasins (Agkistrodon piscivorus), three rattlesnakes (two Crotalus horridus atricaudatus and one Sistrurus miliarius miliarius), one copperhead moccasin (Agkistrodon contortrix contortrix), and one New Guinea brown snake (Demansia olivacea) which belongs to the same family as the North American coral snake. All of the bites have been confirmed clinically, and the offending reptile identified in each instance. The patient was treated by first aid measures (incision and suction, and a tourniquet) for each bite, and has never received antivenom for any of his snakebites. According to Wood, Hoback and Green's clinical classification[6] for the severity of a poisonous snakebite, this patient has had three severe, three moderately severe, and six minimal venenations. Following his last three cottonmouth moccasin bites, the patient experienced periorbital edema and a generalized erythematous rash. After his last moccasin bite he also felt as if his throat and Eustachian tubes were swelling, and he experienced sharp, nonlocalized substernal pains. There is a family history of allergy; the mother has a food allergy. The patient is a robust white man in good health. The physical examination was within normal limits except for a mild systolic hypertension; the blood pressure was 160 systolic and 88 diastolic.

CASE 2.—A 45 year old white woman has no family history of allergy. She began working with liquid and dried snake venoms 12 years ago, and 11 years ago inadvertently pricked her finger on the fang of a dead western diamondback rattlesnake (Crotalus atrox atrox). Pain and swelling of the involved finger occurred, but the swelling was localized there. This incident may be

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classified as one of minimal venenation. No specific treatment was given, and the patient completely recovered in three days. About six months later she began to experience coryza when working around venom, particularly moccasin venom. Occasionally she would break out in a fine generalized erythematous rash if exposed to venom for a long period of time. Her symptoms have grown progressively worse and now include a sensation of swelling in the throat with difficulty in swallowing and breathing. These attacks last for several hours, and are alleviated by antihistaminic drugs. The patient was also bitten by a black widow spider (Latrodectus mactans) 12 years ago. She was ill for three days following this serious bite. Physical examination of this patient was within normal limits.

Materials and Methods

Since these two cases suggested allergy to snake venom, we decided to perform dermatologic patch and scratch tests to confirm the presence of hypersensitiveness. Because snake venom is a highly toxic substance, patch tests were used first. Two persons who had never been snakebitten or exposed to snake venom were used as controls.

Fresh undiluted cottonmouth moccasin (A. piscivorus) and eastern diamondback rattlesnake (C. adamanteus) venom were applied to the opposite forearms of the two patients and the two control subjects by means of 8 mm. circular gauze patches. A patch with normal saline was used as a control on each one. The tests were read in 24 hours.

Because the patch tests were not conclusive, scratch tests were performed on all four subjects 48 hours later. The method employed was to clean the inner aspect of both forearms with an alcohol sponge and make a superficial scratch, 4 to 6 mm. long, with a No. 11 Bard-Parker scalpel blade. Cottonmouth moccasin venom was applied to one forearm and rattlesnake venom was applied to the opposite forearm by dipping a toothpick in the venom and painting the scratch lengthwise. Less than a drop of venom was used on each scratch. The scratch tests were read 20 minutes later.

Results

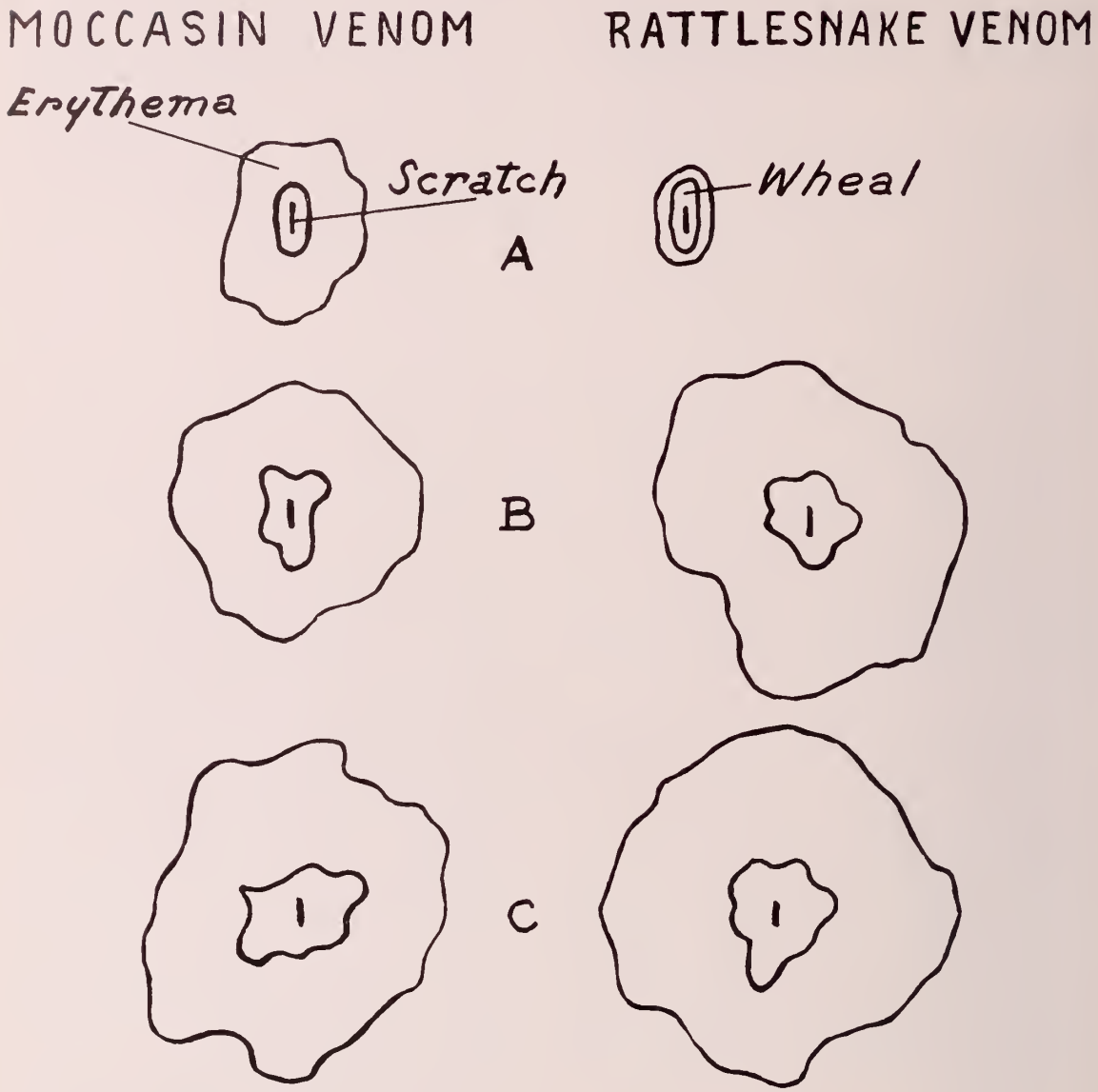
The patch tests gave negative results on both control subjects and on the patient in case 2. The patient in case 1 exhibited a definite positive reaction to rattlesnake venom in 24 hours, which was manifested by an 8 mm. wheal surrounded by an area of erythema 22 mm. in diameter. Itching was present in the area starting five hours after the venom was applied. A similar, but delayed, reaction was obtained about 30 hours after a patch of moccasin venom was applied.

There was a noticeable difference in response to the scratch tests of the control subjects and the allergic patients. Twenty minutes after rattlesnake venom was applied to the control subjects, a wheal was formed which measured 7 by 10 mm., and an area of surrounding erythema was present which measured 10 by 13 mm. The response of the controls to moccasin venom was more pronounced; the wheal measured 8 by 12 mm., and the surrounding erythema measured 18 by 24 mm. A sharp burning pain was experienced by each normal test subject commencing about two minutes after the venom was applied. There was only a 1 or 2 mm. difference in the size of the wheal and the erythema produced by each venom in these subjects; hence the average measurements are given.

In contrast to the control subjects, the allergic patients exhibited a more pronounced response to both of the venoms. The wheals were larger and had pseudopods, and the area of surrounding erythema was much more extensive. In case 2 there was itching in the area of the rattlesnake venom, and in case 1 itching occurred in the area where both of the venoms were applied. Figure 1 illustrates the actual size of the reactions.

In order to gather additional positive evidence of allergy, a modified Prausnitz-Küstner test of local passive transfer of hypersensitiveness was tried. The technic described by Kolmer, Spaulding and Robinson[7] was used. Briefly, 0.1 cc. of serum of the patient in case 1 was injected intradermally into the forearm of one of the control subjects, and 24 hours later the scratch tests were repeated. The responses were much more extensive than in the original tests on this subject; they were almost identical to the responses to the scratch tests of the allergic patient. Figure 1B shows the reaction of the control after he had become hypersensitized, which is in contrast to his original response (fig. 1A).

Some doubt still existed as to the validity of interpreting these results as allergic rather than irritative manifestations since the response of a group of normal subjects who have never been snakebitten was unknown. Twenty normal persons, with no history of snakebite, were scratch-tested with moccasin and rattlesnake venoms. There were four types of response, namely: (1) the erythema produced by moccasin venom was more extensive than that resulting from rattlesnake venom in seven patients; (2) the erythema resulting from both venoms was extensive and approximately equal in six patients; (3) both venoms produced a wheal but little erythema in six patients; and (4) rattlesnake venom produced a more extensive area of erythema than moccasin



A. ORIGINAL RESPONSE OF CONTROL SUBJECT

B. RESPONSE OF SAME CONTROL SUBJECT AFTER INJECTION OF ALLERGIC PATIENT'S SERUM. (PRAUSNITZ-KÜSTNER TEST)

C. RESPONSE OF ALLERGIC PATIENT.

Fig. 1.—Responses to scratch tests with snake venoms (actual size).

venom in one patient. In each of these tests the wheal was approximately the size and shape of those seen in figure 1A. The wheals produced in these normal subjects were smaller and did not exhibit the pseudopods observed in the wheals of the allergic patients, and the surrounding area of erythema was smaller in the normal subjects than that present in the allergic patients. We believe that these four types of response are not a result of technical errors since one of us (H.M.P.) performed all of the scratch tests.

The results of these scratch and passive transfer tests would seem to confirm the presence of venom allergy in these two patients.

Discussion

The venom of North American pit vipers has the potentiality of causing allergy in humans. Weiss[8] demonstrated anaphylactic phenomena in guinea pigs which had been injected with South American snake venoms. He found zoologically related venoms elicited the same response. Repeated snake venom poisoning in the same person is not as rare as some people think. Allen and Neill[9] reported that of 600 cases of snakebite they collected from newspaper accounts with a follow-up questionnaire, 91 were in amateur or professional snake handlers. Watt, Parrish and Pollard[10] described snakebite as an occupational disease for this group. From the two cases reported here and those described in the literature, one may conclude that repeated exposure (bites with or without contact to dried or liquid venoms) to snake venom enhances the possibility of hypersensitiveness developing, including anaphylactic reactions. Very likely, some deaths from poisonous snakebite are the result of anaphylaxis.

These case studies demonstrate that certain venoms elicit an antibody response which produces hypersensitivity to other closely related venoms. For example, the patient in case 2 is allergic to moccasin (A. piscivorus) venom and eastern diamondback rattlesnake (C. adamanteus) venom in spite of the fact that her only episode of envenomation was by a western diamondback rattlesnake (C. atrox). Similarily, the patient in case 1 is allergic to eastern diamondback rattlesnake (C. adamanteus) venom, but has received his bites from other rattlesnake species (S. miliarius miliarius and C. horridus atricaudatus). In support of this phenomenon is the fact that Wyeth's recently developed Polyvalent Antivenin offers protection against many species of North and South American pit vipers although it is made by injecting horses with a mixture of but four venoms. Evidently the action of certain venoms may produce a state of polyvalent hypersensitiveness in man.

Summary

The case studies of two patients who are allergic to North American snake venoms are presented. The presence of hypersensitivity was confirmed by patch and scratch tests made with undiluted fresh venoms.

The evidence presented seems to indicate that, in humans, certain venoms may elicit hypersensitivity to closely related venoms.

It is suggested that some deaths from snake venom poisoning may result from anaphylaxis rather than the toxic effects of the venom as such.

Appreciation is expressed to Mr. Ross Allen and Dr. Wilfred T. Neill of Ross Allen's Reptile Institute, Silver Springs, Fla., for supplying the venom used in this study and for reviewing the manuscript.

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ABSTRACTS

The Study of the Sterile Couple. By M. Edward Davis and Albert G. King. Postgrad. Med. 19:131-143 (Feb.) 1956.

The inability to have children is of serious concern to a fairly large segment of the population. It has been estimated that about 15 per cent of marriages are barren and that in at least 10 per cent of these the failure to have a baby is of sufficient concern to cause the couples to consult a physician. The initial medical contact is extremely important in the ultimate progress, the authors of this comprehensive, well illustrated article point out, for far too often the family doctor contributes little to unraveling the cause of the infertility and indeed may unwittingly decrease the patient's chances of having a baby by postponing indefinitely an adequate sterility investigation. They advocate a complete sterility study in every couple who consult a physician because of their inability to have children and they regard a carefully conducted diagnostic survey as the best therapeutic regimen for infertility. They describe such a study in some detail and point out that it can be carried out by the family doctor, who rarely may need help from the specialist in this field.

Roentgenographic Demonstration of Intestinal Ascariasis in Children Without Using Barium. By Ivan Isaacs, M.D. Am. J. Roentgenol. 76:558-561 (Sept.) 1956.

In this article the author points out that the roentgenographic demonstration of masses of Ascaris lumbricoides in the intestinal tracts of children is sometimes possible without the introduction of contrast mediums. He was able to find only three brief references to this simple means of roentgen diagnosis in the English medical literature and observed that it does not seem to be generally included in the common fund of radiologic knowledge in this country. The roentgenographic visualization is due to the positive shadows of multiple worms contrasted against the gas in a distended segment of small intestine. The characteristic appearance of such worm masses causing partial intestinal obstruction is described, with three illustrative cases. Its recognition may be of occasional diagnostic significance in the detection of vermicular ileus in children.

Tracheostomy Scar Revision. By H. Clinton Davis, M.D., Benjamin Musser, M.D., and L. G. Glasson, M.D. Laryngoscope 65:276-281 (April) 1955.

The ever increasing use of tracheostomy as an adjunct in medicine and surgery has made the physician more aware of the typical secondary intention scar deformities. Often the operation is performed hastily for life-saving reasons without thought of cosmetic planning. Surgical considerations with regard to the revision of these cicatricial lesions serve as a basis for this paper. The several varieties of common tracheostomy scar deformities are presented, and their surgical correction is discussed.

Pelvic Fused Kidney. By A. Lane Miller, Jr., Arthur W. Brown and Gilbert C. Tomskey. J. Urol. 75:17-20 (Jan.) 1956.

Fused pelvic kidney is one of the most unusual congenital anomalies encountered in urology, either clinically or at autopsy. It has been described variously as the lump, shield, cake, or discoid kidney since it presents as an irregularly-shaped fused pelvic mass. The authors found reports of 11 cases in the available literature. They report a case of hydronephrotic fused pelvic kidney in a patient, aged 24 at the time of operation in March 1951, who has thus far had satisfactory results from a plastic repair of the ureteropelvic junction. He was subjected to two postoperative examinations, which showed that the kidneys had improved markedly, as evidenced by lack of infection, nonrecurrence of the hydronephrotic mass, improved pyelographic studies and absence of symptoms. The authors point out that while treatment of necessity must be suited to the individual case, adequate drainage is the primary problem. In their case, this was successfully accomplished by a Y-plasty on the right and by simply freeing the ureter on the left since no other obstruction on that side was evident.

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A Hippocratic Duty Too Seldom Fulfilled

"I will pay the same respect to my master in the science as to my parents and share my life with him and pay all my debts to him. I will regard his sons as my brothers and teach them the science, if they desire to learn it, without fee or contract. I will hand on precepts, lectures and all other learning to my sons, to those of my master and to those pupils duly apprenticed and sworn, and to none other."
(hippocratic oath)

A busy physician's private practice is perhaps the richest source of experience for the creation and accumulation of skills in the diagnosis and treatment of disease. Any observant physician—as most of us are—has in his private practice, no matter its type, unlimited daily opportunities for research into the causes and disturbed mechanisms which bring on diseases and into the means of preventing and correcting them. After 10, 20 or more years of such work, he becomes the possessor of a vast treasure of medical knowledge. Unfortunately, the acquiring of such vast knowledge conveys increasing demands upon the physician's time, and usually, the more he learns, the less time is left to him for conveying that knowledge to others.

Many of the reports in current medical literature referring to new discoveries upon the causes and ways of treating several illnesses are read by many practitioners who find they had themselves long ago reached the same understanding of the problem at hand, but could never find enough time to write about their findings and see their reports published.

It is our duty, included in the Hippocratic Oath, to teach others what we have learned so that medicine's progress shall continue forever for the benefit of mankind. It is really a pity that many of us seem unable to find enough time to fulfill this pledge. Because of that failure, there is an obvious imbalance in medical literature between the tremendous number of reports published by specialized research men and women, dealing mostly with basic science subjects, and the reports which should be published by practicing physicians regarding the application of such technical data to the practical everyday management of patients.

It seems desirable that many more practicing physicians would make a part of their yearly schedule of work the reservation of some time off from their daily routine, not only to enjoy an occasional pleasant vacation—which is also a judicious and salubrious practice—but also to spend a few extra hours for the purpose of jotting down some of the observations they have made in the course of their practice which might be of benefit to other practicing physicians and, most importantly, to their patients.

As a physician rounds out years upon years of busy practice, his judgment becomes sharper and is polished by experience; his mind never ceases to mature. A time comes, after years of such continuous study and observation, when he must realize that at least some of his treasured knowledge should be imparted to others, for all men should share in what each one of us learns. Our patients teach us, and to them we are indebted. What we learn from those under our care and study should also benefit others who may be in need of such knowledge.

It is not necessary to be either a "professor" or a specialized researcher working in elaborate laboratories to be able to contribute some new ideas, new concepts, new technics to medicine. Some of the most valuable contributions have been made by simple practitioners from shrewd deductions made while caring for and observing their own patients. The more intimate the relationship between a physician and his patients the more opportunities are afforded for observation and for learning new facts from them. The scourge of yellow fever was for many years a deterrent to international commerce and to the development and progress of many nations. Highly scientific research studies had been carried on for many years by well trained and competent men, and still no solution to the problem had been found when the Spanish-American War was ending in Cuba in 1898, with more casualties occurring in the three armies involved due to the yellow fever epidemic than to bullets. A modest family physician with very limited resources had long before made a shrewd and simple observation. It was so simple that he was repeatedly laughed at for his conviction that yellow fever was transmitted by a mosquito. He had no laboratory facilities except the crude cages he had made himself to trap mosquitoes in order to learn how to identify and differentiate the varieties then overwhelmingly prevalent in Havana. Nevertheless, by patiently watching around he had learned that wherever a focus of the epidemic appeared in a neighborhood of the war-crowded city, the mosquito Culex fasciatus or Stegomia fasciatus, now called Aedes aegypti, was prevalent in the area.

He had published his observation in a short article in the American Journal of the Medical Sciences in 1886. Though he had proved it by actually producing the plague in five men volunteers who had agreed to be bitten by mosquitoes which had previously bitten yellow fever victims, it took almost 15 years for this fact to be accepted and applied to the elimination of the disease.

To the end-of-the-century mind his concepts, which the present generation takes for granted, were little less than absurd. The scientists assigned by the United States occupation forces to study the problem were most reluctant to accept them. It was only in desperation, when all other approaches had been exhausted in repeated failures, that Walter Reed in 1900 turned to Carlos Finlay, the "little crazy doctor," and listened to his simple observations and deductions. Within a few weeks Finlay's theory was proved at the cost of a few additional heroic lives, with the resulting saving of untold millions more. The campaign for eradication of the mosquito turned a dirty colonial city, plagued with yellow fever for over 150 years, into one of the cleanest capital-ports in the world, and the construction of the Panama Canal, delayed for many years, became possible.

Finlay's contribution to the welfare of mankind is by no means unique among the experiences of modest practicing physicians, though it was one of the greatest. Innumerable equally worthy contributions have been made by many other modest men of medicine from similiar simple observations and shrewd deductions. James Lind's observations as a royal navy physician leading to the conquest of scurvy, those of Semmelweis which eliminated puerperal fever, and many others, are enshrined in medicine's annals.

How many other contributions just as useful to mankind could be harvested from today's doctors working everyday at their practices?

Modesty and timidity usually go together, and courage is a rarer virtue than prudence. If Finlay's modesty and prudence had not been overcome by the courage of his convictions, many more lives might have been lost before the problem of yellow fever would have been solved.

It is easy—and lazy—to say: "There are too many medical articles being published already.

Why should I stick my neck out?" If, however, you have learned something, no matter how simple or unorthodox it may appear, if you possess some knowledge that you have been able to use in your own practice again and again with benefit to your patients, if you have the conviction that such bit of knowledge is really useful, do not keep it to yourself. A simple statement of facts learned and of your own experience with your application of them in a communication to your fellow practitioners is your duty under your Hippocratic Oath. If you are too shy or your time is too short for a lengthy article, a short "letter to the editor" of your Journal many be sufficient. More valuable contributions have been made to medical literature in such short report forms than in many extensive and verbose papers; but no matter how you do it, write down your subject clearly and concisely and submit it.

Your contribution may or may not be published. It is the duty of the editorial board of a medical journal to assist you by checking your facts as far as possible and avoid gross errors in print. If what you have to say comes from the sound, mature and critical mind of a practicing physician of experience, the chances are mostly in your favor. Your contribution may or may not be of epochal importance, but if it will—in any way—help someone else, its publication will earn for you a great personal satisfaction and a place among those who constantly strive for a better practice of medicine and for a healthier and happier humanity.

American Medical Association Meets in New York

June 3-7, 1957

Elaborate preparations are nearing completion for the 106th Annual Meeting of the American Medical Association, which will be held in New York City early next month. Opening on June 3, the sessions will continue through June 7. Registrations were heavy as early as January, indicating an exceptionally large attendance, which will doubtless exceed that of the 1953 New York meeting. Advance hotel reservation forms have been appearing frequently in the Journal of the American Medical Association since the first of the year, and physicians are reminded that all reservations for New York hotels listed should be cleared through the A. M. A. Subcommittee on Hotels before May 25. The headquarters hotel is the Waldorf-Astoria, and the Roosevelt Hotel is the Woman's Auxiliary Headquarters.

Members from every state in the union and visitors from every country will converge on New York for the meeting, making the city the medical capital of the world in June. Nowhere could one find a more fruitful source of new information on the advances of scientific medicine than at this outstanding session. The broad variety of subjects covered will interest all branches of the profession. For nearly five full days the program provides lectures, scientific exhibits, technical exhibits, color television and motion picture presentations which comprise a comprehensive short course in postgraduate medical education. Individual physicians will have ample opportunity to discuss their problems with demonstrators in the scientific exhibits.

For some 18,000 physicians from all over the country the focal point of the scientific program will be the Coliseum, New York's new exhibition hall, which boasts such facilities as air conditioning, escalators, elevators, a cafeteria, and snack bars. Four floors will be devoted to technical and scientific exhibits, many of the scientific meetings, and the color television program. For the first time, a foreign air will be added to the regular medical film program, to be held at the Barbizon Plaza Hotel. More than 20 foreign countries are sending special films, dealing with many aspects of medical science, to the "international medical film program."

The general scientific program on Monday morning, June 3, will be a review of recent progress in surgery, while the afternoon session will deal with recent advances in medicine. Tuesday morning's general meeting will feature a discussion on the use and abuse of mood-altering drugs in daily practice. Formal section meetings will run from Tuesday afternoon through Friday morning. Many of the sections will combine to present special symposiums and panel discussions. A session on legal medicine will be featured by a mock trial involving the testing of drinking drivers. Special exhibits on fractures, diabetes, peri-

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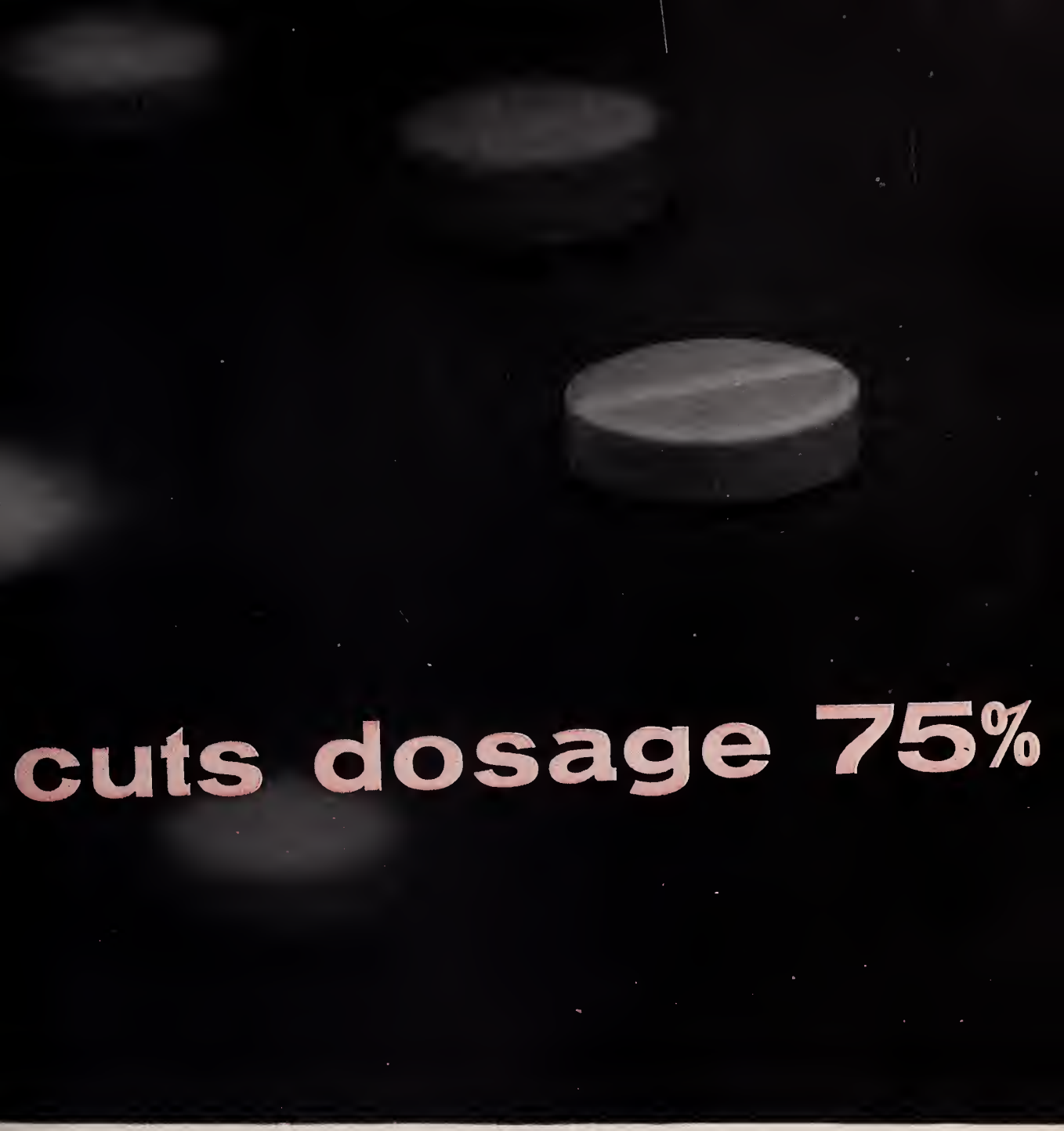

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natal mortality, pulmonary function testing, fresh tissue pathology, arthritis, and nutrition also will be presented.

At this meeting a change will be initiated in presenting the annual Joseph Goldberger Award in clinical nutrition. The award will be presented to the recipient at the opening session of the House of Delegates. The Board of Trustees in cooperation with the Nutrition Foundation established the $1,000 award to serve as a stimulus to medical investigators in advancing the frontiers of public and personal health, with special reference to the significance of good nutrition. In addition to the award, named in honor of the late Joseph Goldberger who discovered the cause and treatment of pellagra, there will be a Goldberger lecture by the recipient at one of the section meetings. Both the award and the lecture will become an annual feature at the June meetings of the American Medical Association.

It seems particularly timely that among the innumerable attractions of New York City there is a current Broadway hit which pays homage to the doctor. "The Most Happy Fella," a musical with light opera overtones based on Napa Valley, the wine-producing center of California, has "The Doctor," played by Keefe Kaldenberg, as one of the principal characters. He is the general practitioner of the community. "Seldom has the medical profession been placed in a better light," comments Dr. George F. Lull, Secretary-General Manager of the American Medical Association. "The role of the physician is played with sympathy and understanding. One can not but wonder if the author, Frank Loesser, did not have in mind Dr. Dwight Murray of Napa, president of the A. M. A., when he depicted the doctor with his broad understanding, humanity, and sympathy for his patients, and made him a central figure in the community's activities."

Attractive post-session tours to Europe and Bermuda are being offered. Of two European tours, one of 24 days includes France, Italy, Switzerland, Belgium, and France, and the other, requiring 38 days, visits England, Belgium, Holland, Germany, Switzerland, Austria, Italy and France. In cooperation with the World Medical Association, special scientific sessions of exceptional interest have been planned in London, Paris and Geneva. The post-session program also includes three trips to Bermuda—one of five days, one of eight days by air, and one of eight days by air one way and by steamer one way.

Naturopathy in Florida Officially Investigated

Governor Collins recently released a report on the practice of naturopathy in Florida which deals a heavy blow to naturopaths in the state. The report, based on an investigation ordered by the Governor and extending over a period of several months, recommends that the state legislature "abolish the practice of naturopathy and prohibit its future practice in this state." It is estimated that there are approximately 350 naturopaths in the state.

Last September, the Governor commissioned Mr. P. W. Sapp, Inspector, Bureau of Narcotics, Florida State Board of Health, to inquire into the operations of the State Board of Naturopathic Examiners and into the background of those examined by this board. The 109 page report summarizes the results of his investigation. In releasing the report, Governor Collins stated:

"The protection of the health of the citizens of the State of Florida is one of the primary functions of government.

"The practice of naturopathy has caused a great deal of controversy in the courts and legislature for many years in our state.

"In view of these considerations, and irregularities which have been called to my attention in recent months, I requested that an investigation of naturopathy in Florida and its status over the nation be conducted by a qualified person selected by the State Board of Health.

"On September 4, 1956, Mr. P. W. Sapp, Inspector, Bureau of Narcotics, State Board of Health, was assigned to this task.

"I have submitted a copy of this report to the State Board of Naturopathic Examiners and if such is desired a hearing will be provided prior to the formulation of any recommendations I shall make in respect to this matter to the Legislature."

The details of so-called schools claimed as sources of diplomas by naturopaths licensed in Florida constitute a particularly revealing feature of the report. In regard to naturopathic education the report said:

"Information pertaining to naturopathic education is difficult to obtain because schools are small affairs of a fly-by-night character with few students and several months of investigation including correspondence and on the spot visiting revealed no school which confines its teachings to naturopathy. In every instance where any type of school existed, naturopathy was nothing more

than part of a course given for the training of chiropractors."

The investigator of these so-called schools further reported that:

"None had even one adequately trained teacher on the faculty, for there is no naturopathic school where they could be adequately trained;

"None had one worthily equipped laboratory;

"None conducted a clinic in which a wide variety of common diseases could be studied;

"None had any affiliation with a worthy hospital;

"None apparently has ever been surveyed by any recognized educational authorities to justify the extravagant claims made in their brochures and catalogues;

"None existed where any internship, externship or preceptorship is required;

"Their liberal granting of degrees has for its purpose the accommodation of the individual in his quest for state licensure, rather than qualification as a healer in any one phase of the healing art;

"All owed their existence to the demand for, and to the fact that they offered, a short cut to the practice of medicine;

"The operators of several were involved and indicted in diploma mill frauds; and

"All proceeded on the basis of unproved theory, ignoring the lack of indorsement by any recognized educational institution."

The naturopathic situation in Florida is unique. The state has the opprobrious distinction of being the only one in the entire United States in which these so-called drugless healers are, by reason of judicial interpretation of licensing laws, able to dispense and prescribe narcotics and antibiotics.

Inquiries to the Governors of each of the 47 states other than Florida regarding the legal status of naturopathy in their respective states revealed that 33 states do not recognize or license naturopaths. Six states formerly recognized them, but currently do not; among these are Georgia and South Carolina whose legislatures abolished the practice of naturopathy in 1956. Only four states currently license them. From four states there was no reply. It is noteworthy also that "naturopathy is not recognized in any capacity as a branch of the healing arts by any department or agency of the federal government."

On March 7, 1957, the Florida Medical Association made its position in the matter clear by issuing the following statement:

"The Florida Medical Association, through its House of Delegates, has approved the support of a bill in the 1957 Session of the Florida Legislature to abolish the practice of naturopathy in Florida. This is the same position it has held for many years.

"The extensive investigation into naturopathy which was requested by Governor LeRoy Collins presents irrefutable evidence that the laws allowing these so-called drugless healers to practice in Florida should be repealed. The report reveals that naturopathy is a fraud which should not be imposed upon the general public of our state.

"Governor Collins and the State Board of Health should be highly commended for undertaking this expose to protect the health needs of the public, and we hope the members of the Florida Legislature will recognize their public duty in this respect and pass legislation outlawing this vicious practice and fraud in Florida."

Dr. Joseph Halton Receives First Life Membership Certificate

The Sarasota County Medical Society at its meeting on April 9 honored Dr. Joseph Halton, who this year rounds out 50 years of practice in Sarasota. Anticipating by four weeks its plan to initiate at the forthcoming annual meeting in May the practice of awarding a Life Membership Certificate to all active members of 35 years' standing, the Florida Medical Association presented to Dr. Halton on this occasion the first such award. Dr. Francis H. Langley of St. Petersburg, President of the Association, made the presentation.

Dr. Samuel Kaplan of Sarasota, the president of the Sarasota County Medical Society, presided at the dinner meeting, which was devoted to special recognition of Dr. Halton for his half century of service in the community. The members enjoyed Dr. Halton's reminiscences as the highlight of the evening's entertainment.

Born in St. Helens, England, Dr. Halton came to the United States at the age of eight years and resided in Ohio and Indiana. In 1906, he received his medical degree from the University of Cincinnati and the following year he established his practice in Sarasota. A pioneer in the area, he surmounted the difficulties of medical practice and also became one of the early builders of the city of his choice. He engaged in intensive research in hookworm disease, so prevalent in Florida in the early years of this century, and

was a pioneer in x-ray work. He was also one of the first physicians in the state to use insulin with great success.

Ever a student bent on progress in medical and surgical research, Dr. Halton has kept abreast of the tremendous advances in medicine across the last half century by periodic postgraduate study in the leading clinics of this country and in the clinics of France, England and Scotland. The Halton Clinic for Children, established in his own private hospital, where operations have been performed on over 2,000 children, is well known. Possessor of a fine baritone voice, Dr. Halton has found time through the years to be generous with his musical talent as well as his professional skill. For several years he trained and directed the large vested choir of the Episcopal Church of the Redeemer.

Congratulations to this stalwart, forward-looking member of his county and state medical societies for his achievements through the years and his devoted service to mankind. May he continue to carry on in the best tradition of his profession for many years to come.

Graduate Medical Education

Hematology Seminar
June 20-22

The Seminar on Hematology, to be held June 20-22 at the College of Medicine of the University of Florida at Gainesville, will feature Dr. Steven O. Schwartz, Associate Professor of Medicine at Northwestern University and Director of the Hematology Laboratories at the Hektoen Institute for Medical Research of the Cook County Hospital in Chicago, as the principal speaker. Assisting Dr. Schwartz in presenting the program will be Dr. John B. Ross, Medical Director of the Jacksonville Blood Bank in Jacksonville, Dr. Sanford A. Mullen, pathologist at St. Vincent's Hospital in Jacksonville, and Dr. Jacob Neber, hematologist at Mt. Sinai Hospital of Greater Miami, Miami Beach. Advance registration is requested as it is planned to distribute material prior to the course to those wishing to participate in this program. The registration fee is $25. A luncheon for the group will be held on Thursday with Dr. George T. Harrell Jr., Dean of the College of Medicine, as the guest speaker.

Schedule for Seminar on Hematology

THURSDAY, JUNE 20

9:00 Registration
9:30 Introductory Remarks: "The Role of Hematology as a Diagnostic and Therapeutic Discipline"—Dr. Schwartz
10:30 Recess
10:45 "The Diagnosis and Treatment of Hemolytic Anemia"—Dr. Neber
11:30 Recess
11:40 "Discussion of Illustrative Cases"—Dr. Schwartz
12:45 Luncheon
Guest Speaker: Dr. George T. Harrell Jr.
2:30 "Abnormal Hemoglobins"—Dr. Ross
3:15 Recess
3:25 "Discussion of Illustrative Cases"—Dr. Schwartz
4:15 Demonstration

FRIDAY, JUNE 21

9:30 "Discussion of Illustrative Cases"—Dr. Schwartz
10:10 "Plasma Proteins"—Dr. Ross
11:00 Recess
11:15 "The Sundberg Technique of Bone Marrow Aspiration"—Dr. Mullen
12:15 Demonstration
2:00 Panel Discussion: "Hematology and Its Relation to Diagnostic Medicine"
3:30 Recess
3:45 "Discussion of Illustrative Cases"—Dr. Schwartz

SATURDAY, JUNE 22

9:30 "Macroscopic Hematology: What One Should See Without a Microscope"—Dr. Schwartz
10:30 "Chemotherapy of Chronic Leukemia" Dr. Neber
11:15 Recess
11:30 Question and Answer Period—Dr. Schwartz

Annual Graduate Short Course
June 24-28

The Twenty-Fifth Annual Graduate Short Course will again be presented this year by the Division of Postgraduate Education of the College of Medicine of the University of Florida, in cooperation with the Florida Medical Association and the Florida State Board of Health. The Short Course will be held the week of June 24-28 at the College of Medicine in Gainesville. The complete program together with a brochure containing information on travel, hotel, and recreational facilities will be mailed to all physicians in the state the latter part of May. Assistance in making hotel and travel arrangements may be secured by contacting the office of the Division of Postgraduate Education, 1625 Riverside Avenue, Jacksonville 4.

Tours of the College of Medicine will be ar-

Schedule for Short Course

	Monday June 24	Tuesday June 25	Wednesday June 26	Thursday June 27	Friday June 28
8:00	**Registration**				
9:00	**Medicine** "Diagnosis and Treatment of Angina Pectoris" Dr. Warren	**Medicine** "Differential Diagnosis of Diseases of the Lungs" Dr. Warren	**Pediatrics** "Cytomegalic Inclusion Disease of the Newborn" Dr. Birdsong	**Surgery** "Surgery of the Adrenal Glands" Dr. Cantrell	**Gynecology** "Management of Hydatidiform Mole and Chorioepithelioma" Dr. G. S. Jones
10:00	**Pediatrics** "Emergency Condition of the Newborn Infant" Dr. Birdsong	**Pediatrics** "The Care of Premature Infants" Dr. Birdsong	**Medicine** "Shortness of Breath" Dr. Warren	**Gynecology** "Cancer of the Cervix and Body of the Uterus" Dr. Jones	**Surgery** "The Use of Operative Cholangiography in Operations on the Gallbladder and Common Duct" Dr. Cantrell
11:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**
11:30	**Laboratory Diagnostic Methods** "Cardiac Catheterization as a Diagnostic Aid" Dr. Otis	**Laboratory Diagnostic Methods** "Newer Methods for the Study of Proteins" Dr. Fried	**Laboratory Diagnostic Methods** "New Laboratory Diagnostic Methods for Parasites" Dr. Hunter	**Surgery** "Current Concepts of the Treatment of Portal Hypertension" Dr. Cantrell	**Gynecology** "Intersexuality and Allied Conditions" Dr. Jones
12:30	**Lunch**	**Lunch**	**Lunch**	**Lunch**	**Lunch**
2:00	**Pediatrics** "Infant Feeding" Dr. Birdsong	**Medicine** "Digitalis and Quinidine Therapy" Dr. Warren	**Medicine** "Edema" Dr. Warren	**Gynecology** "Diagnosis and Management of Infertility" Dr. G. S. Jones	**Surgery** "The Present Status of Appendicitis" Dr. Cantrell
3:00	**Recess**	**Recess**	**Recess**	**Recess**	**Recess**
3:15	**Medicine** "The Management of Congestive Heart Failure" Dr. Warren	**Medical Panel:** "Use and Abuse of New Therapeutic Agents" Drs. Warren, Birdsong, and Martin	**Pediatrics** "Congential Hemolytic Disease of the Newborn" Dr. Birdsong	**Surgery** "The Rational Treatment of Spontaneous Pneumothorax" Dr. Cantrell	**Surgical Panel** "Treatment of Cancer with Particular Reference to Radical Surgery" Drs. G. S. Jones, Jones and Cantrell
4:15	**Recess**		**Recess**	**Recess**	
4:30	**Laboratory Diagnostic Methods** "The Application of Phase Microscopy" Dr. Odor	Moderator: Dr. George T. Harrell Jr.	**Laboratory Diagnostic Methods** "Laboratory Isolation and Identification of Viruses" Dr. Gifford	**Gynecology** "Amenorrhea" Dr. Jones	Moderator: Dr. Thomas H. Bates
5:30			Cocktail Hour		

ranged so that the physicians in attendance will have an excellent opportunity to familiarize themselves with the new medical school.

The faculty is as follows:

Medicine: Dr. James V. Warren, Professor of Medicine, Duke University School of Medicine, Durham, N. C.

Pediatrics: Dr. McLemore Birdsong, Professor of Pediatrics, University of Virginia School of Medicine, Charlottesville, Va.

Gynecology: Dr. Howard W. Jones Jr., Assistant Professor of Gynecology, The Johns Hopkins University School of Medicine, Baltimore.

Dr. Georgeanna S. Jones, Staff Member, The Johns Hopkins Hospital, Baltimore.

Surgery: Dr. James R. Cantrell, Assistant Professor of Surgery, The Johns Hopkins University School of Medicine, Baltimore.

Laboratory Diagnostic Methods: College of Medicine Staff: Melvin Fried, Ph.D., Assistant Professor of Biochemistry; George Gifford, Ph.D., Assistant Professor of Microbiology; George W. Hunter III, Ph.D., Interim Professor of Biological Science; D. Louise Odor, Ph.D., Assistant Professor of Anatomy; and Arthur B. Otis, Ph.D., Professor and Head of the Department of Physiology.

Panels: Dr. George T. Harrell Jr., Dean, College of Medicine, University of Florida, Gainesville. Dr. Samuel P. Martin, Professor of Medicine. College of Medicine, University of Florida. Gainesville.

Florida Association of Blood Banks Eleventh Annual Meeting Miami Beach, May 10-12

Planned to follow immediately after the annual convention of the Florida Medical Association at the nearby Hollywood Beach Hotel, the Eleventh Annual Meeting of the Florida Association of Blood Banks will be held on Friday, Saturday and Sunday, May 10, 11 and 12 at the Golden Gate Hotel at 194th Street and Collins Avenue, Miami Beach. The excellent program with its nationally prominent speakers and their well chosen subjects should attract many physicians from throughout the state who will attend the Florida Medical Association meeting and who doubtless will wish to remain over for this meeting.

Paul R. Cannon, M.D., Professor of Pathology at the University of Chicago, the School of Medicine, and distinguished authority on protein metabolism and electrolyte balance, will be the principal guest speaker. He will speak on Saturday on "The Role of Amino Acids in the Maintenance of Life."

Among the eminent guest speakers is Eric E. Muirhead, M.D., of Dallas, President of the American Association of Blood Banks, whose subject is "Some Characteristics of Contaminated Blood." The other invited lecturers and their subjects are: Merlin L. Trumbull, M.D., Baptist Memorial Hospital, Memphis, "The Importance of a Code of Ethics in Blood Banking;" Coye C. Mason, M.D., Chicago, "Use of Reclaimed Plasma in Hospital Transfusion Services;" Lloyd R. Newhouser, M.D., John Elliott Blood Bank of Dade County, Miami, "Preliminary Report on Hemoglobin Levels in the Aged;" O. B. Hunter, M.D., Washington, D. C., "Use of Radio-Isotopes as Related to Blood Transfusions;" E. R. Jennings, M.D., Woman's Hospital, Detroit, "Studies in Hepatitis;" Joseph A. Hertel, M.D., Atlanta, "The Nature of the Red Cross Blood Programs in the United States;" Paul Cantor, M.D., L.L.B., Georgetown University School of Law and Medicine, Washington, D. C., "Medico-Legal Aspects of Blood Banking;" Mrs. Edna T. McPhee, John Elliott Blood Bank of Dade County, Miami, "Public Relations and Donor Procurement in Blood Banking;" and Mrs. Mary Rand, Central Florida Blood Bank, Orlando, "A Pension Plan for Blood Banks."

Medicolegal Institute Held

The Florida Medical Association, the Florida Bar and the University of Miami School of Law sponsored a medicolegal institute on March 22 and 23, 1957 at the McAllister Hotel in Miami. Dr. W. Tracy Haverfield of Miami, a member of the Public Relations Advisory Committee holding the special assignment of liaison officer with the Florida Bar, represented the Association in arranging for this unique and constructive program. A medical and a legal speaker discussed each subject. Each lecture period was half an hour in length and was followed by a half hour period of questions and answers.

Among the subjects discussed were: "Relationship of Cancer and Trauma," "Relationship of Trauma and Strain on the Heart and Vascular System," "Evaluating the Effects of Head Injury Using Psychometric Tests and EEG," "The Follow-Up of Whiplash Injuries After Settlement of the Case," "Soft Tissue Trauma," "Electromyography as an Aid in Evaluating Nerve and Muscle Injury," "Post-Traumatic Arthritis," "Back Injury—Its Cause and Sequelae" and "Disability Evaluation."

Food for Thought

At the beginning of each new session of the Congress, the Washington staff of the American Medical Association makes a practice of calling on all new congressmen. Two staff members, early in the present session, stopped in to chat with Congressman Dingell of Michigan, who succeeded his late father, a legislator all too well known to the medical profession for many years. They found him busy cutting and pasting a new bill.

"You gentlemen won't like what I'm doing," he said, "because I'm getting ready to reintroduce a new version of the old Wagner-Murray-Dingell bill." As he continued clipping, he observed, "The new bill is going to be much smaller than the one introduced the last time."

With that, he held up a substantial number of pages and dropped them in the wastebasket. "These items," he remarked, "have already been enacted."

This revealing conversation provides a bit of provocative information which should help to arouse the medical profession from its present apathy. Socialized medicine is by no means a dead issue. A timely warning was sounded by President Dwight H. Murray of the American Medical Association at the recent Seattle clinical meeting of that body. "Today," he said, "the medical profession along with business and industry is caught between those who desire to promote sound government and those who desire even more intensely to perpetuate party power. Unfortunately, in recent years a benevolent federal government appears more attractive to the voting public than the preservation of individual freedom. Medicine must do its utmost to reverse this trend."

"In my travels around the country as your representative the last 18 months, . . . " he continued, "I have seen too much complacency over governmental encroachment into medical affairs. And I am deadly serious when I say to you that apathy by the few, or by the many, can be detrimental to all.

"No nation can merely reap the benefits of freedom; it also must sow seeds of freedom.

"In medicine the situation is the same. If an apathetic medical profession takes its freedom for granted, it will be the beginning of the end. A strong, free profession must work for freedom so that it may live in freedom."

Dr. Murray's words of caution and his appeal for vigilance are definitely in order. They are also given unique emphasis by the pages of the old Wagner-Murray-Dingell bill, representing enacted items, which the new Congressman Dingell consigned to his wastebasket even as he prepared a new version of the obnoxious bill.

How Would You Improve The American Medical Association?

If you were the president of the American Medical Association, what changes would you make in the way it is run? Five hundred physicians were recently asked to suggest the changes they would recommend under such circumstances. Questioned in a nationwide survey, they most frequently called for closer ties with the individual physician and for further improvement in public relations.

Approximately one doctor in five thought the world's largest medical association should get closer to individual doctors, perhaps even poll their ideas on important subjects to get a more accurate indication of their thinking. A smaller number thought there should be a greater representation of young physicians within the organization.

Improvement in public relations and public information was second in importance among the changes suggested. Concentration on these areas was deemed advisable by 14 per cent of the doctors consulted in the survey.

Social security or pensions for doctors were cited by 9 per cent. About 5 per cent requested liberalized hospital affiliation requirements, and nearly the same number suggested higher standards for practice. Approximately one out of 20 also thought improvements should be made in the Journal of the American Medical Association.

It was the opinion of 3 per cent of the participants that opposition to government medicine should be strengthened by the association, and 2 per cent called for elimination of fee-splitting. Only 2 per cent suggested increased postgraduate training.

About one doctor in 10 thought the association needed no improvement, finding it satisfactory as it is. One wonders if these percentages would carry over to the state and county medical societies in Florida and elsewhere throughout the nation.

The One Hundred Sixth Annual Meeting of the American Medical Association is being held in New York City, June 3-7, 1957. The headquarters hotel is the Waldorf-Astoria. The Woman's Auxiliary is meeting in the Roosevelt Hotel.

OTHERS ARE SAYING

Editorial

The beginning of a new year brings many thoughts as to the future progress of the medical society and of the multiple problems that are always presenting themselves.

What subjects are paramount on the agenda for the year? What are our combined problems that we should try to remedy?

Do we need more physicians and if so, what type? Specialist, general practitioner, young well trained men or an older group? Should we as a society try to attract more physicians into our area by giving them a green light and a welcome hand or should we be a little less eager to entice new men into this area. We have over seventy physicians for our general population. Are we justified in recommending our area to new men when we know how low the patient-doctor ratio is. Should the county society receive them with open arms, or should we look the applications over with a more serious attitude. Shouldn't the admission to the county society be sought after and not pushed onto every new applicant. Admission to our society means that we have placed a stamp of approval on the new physicians. Certainly, somehow we should be given the opportunity and pleasure of seeing, knowing and observing the new applicant for a period of time. Isn't it also true that perhaps these new physicians would also like to observe us — our policy and practice, before becoming part of our organization.

Our first responsibility is to our patient and if our patients are to place any faith in us as an organized group of physicians, shouldn't we be able to say to them that this doctor is a member of our county society and that by being a member of our society, he practices good medicine; that he lives up to the standards of medicine practiced in our society and therefore is a well qualified individual to take care of their medical problem.

We as a group must set our goal high to continue to hold the respect and privileges that were given to us by our predecessors in the art of the practice of medicine.

The Bulletin, Sarasota County Medical Society
January, 1957

CLASSIFIED

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

INTERNIST: With 4 years practice. Board certified. 32 years old. Florida license. Licensed to use radioisotopes, seeks consultation or hospital type of practice. Not interested in "family type" house call practice. Protestant, married, Southerner. Write 69-220, P. O. Box 2411, Jacksonville, Fla.

WANTED: Physician with Florida license. Interest in Physical Medicine and Geriatrics. State qualifications in writing. The Miami-Battle Creek, Miami Springs, Fla.

CLINIC MANAGER: Position desired as manager of group clinic. Experience: auditing and hospital. Education: B. S. (Business Administration) and M.S. (Hospital Administration). Write 69-218, P.O. Box 2411, Jacksonville, Fla.

WANTED: Specialist in Obstetrics and Gynecology to associate with group in Dade-Broward area. Board man preferred. Write age, training, chronology of medical experience, reference. Write 69-222, P. O. Box 2411, Jacksonville, Fla.

INTERNIST (Cardiology): Desires association with established physician or group. Florida license. Diplomate. F. A. C. P. Middle aged. Protestant. Write 69-223 P. O. Box 2411, Jacksonville, Fla

FOR SALE: Doctor's handsome, gold custom made Nu Sigma Nu, ring with 1.5 Kt. diamond set in onyx; white gold crest. $1200. Also new Hamilton watch, $45.00. Write P.O. Box 1974, Orlando, Fla.

FOR SALE: One set trial lenses ophthalmoscope, McIntosh galvanic generator, Fischer Ultra sound M. 2500,-Tonsel instruments, OB bag with instruments, Dental forceps, instrument cabinet. Write S. A. Winsor, M.D., Box 6, Pompano Beach, Fla.

INTERNIST WANTED: Established certified internist desires associate. Florida license, certified or board eligible. Give full background in first letter. Write 69-224, P. O. Box 2411, Jacksonville, Fla.

OBSTETRICIAN-GYNECOLOGIST: Completing residency July 1957. Florida license. Family. Age 30. Category IV. Desires group practice or association. Write 69-225, P. O. Box 2411, Jacksonville, Fla.

PEDIATRICIAN: Board eligible. Florida license. University trained. Military obligations completed. Desires association with group of pediatricians (one to three). Available September 1, 1957. Age 30. Write 69-226, P. O. Box 2411, Jacksonville, Fla.

GENERAL PRACTITIONER WANTED: Will gamble that new medical building is ideal location. Rent absolutely free to right doctor for office and apartment until established, then reasonable. Write A. A. Edwards, 2030 Oak Terrace, Sarasota, Fla.

WANT TO BUY: Used binocular microscope suitable for medical student. Write 69-227, P. O. Box 2411, Jacksonville, Fla.

WANTED: Young energetic Internist with special interest in Gastroenterology to associate with established Internist in rapidly growing central Florida city. Excellent hospital facilities. Write 69-228, P. O. Box 2411, Jacksonville, Fla.

X-RAY EQUIPMENT: Used Keleket 200 MA, two tube, reconditioned and refinished. Carries new equipment guarantee. Includes new rotating anode tube. Call Keleket office — Miami-Tampa-Orlando-Jacksonville-West Palm Beach.

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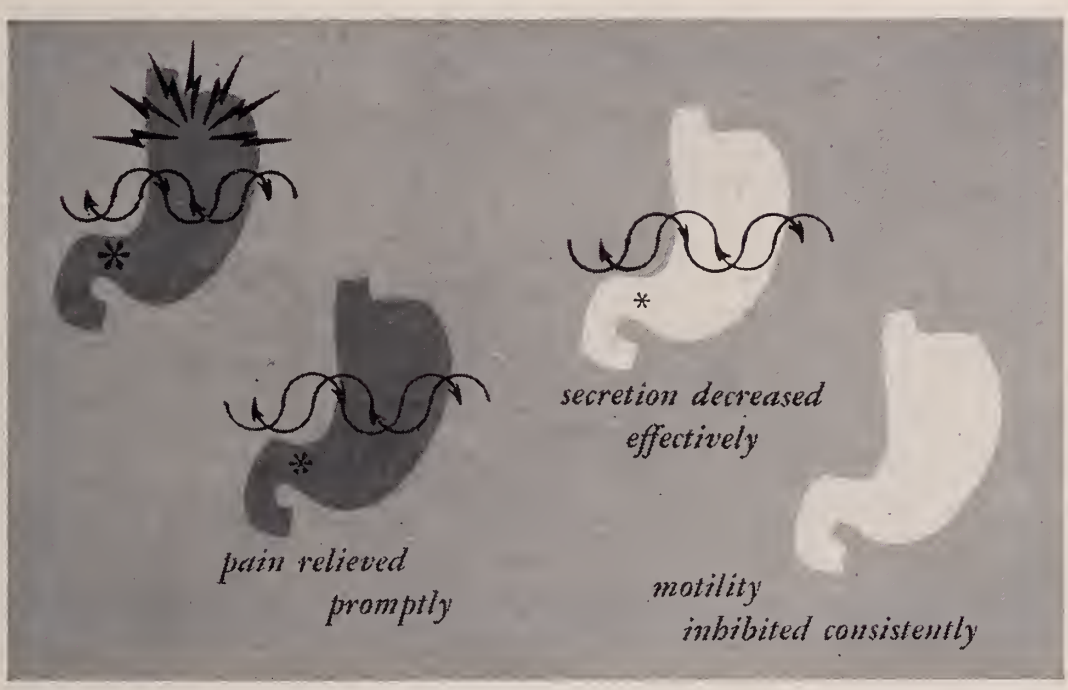
Pro-Banthine®...
A Primary Drug in Peptic Ulcer



Among the many clinical indications for Pro-Banthine (brand of propantheline bromide), peptic ulcer is foremost. During treatment, Pro-Banthine has been shown repeatedly to be a singularly valuable agent when used in conjunction with diet, antacids, sedation and psychotherapy as required. Lichstein and his associates* report that Pro-Banthine "proved almost invariably effective in the relief of ulcer pain, in depressing gastric secretory volume and in inhibiting gastrointestinal motility. The incidence of side effects was minimal. . . ."

The therapeutic utility and effectiveness of Pro-Banthine in the treatment of peptic ulcer are repeatedly confirmed in the medical literature. Dosage: One tablet with each meal and two tablets at bedtime. G. D. Searle & Co., Chicago 80, Illinois, Research in the Service of Medicine.

*Lichstein, J.; Morehouse, M. G., and Osmon, K. L.: Pro-Banthine in the Treatment of Peptic Ulcer. A Clinical Evaluation with Gastric Secretory, Motility and Gastroscopic Studies. Report of 60 cases, Am. J. M. Sc. *232*:156 (Aug.) 1956.

SEARLE

STATE NEWS ITEMS

The Third Annual Central Florida Medical Meeting, sponsored by the Orange County Medical Society, was held at Orlando the middle of March with a total registration of 294. There were 191 physicians in the group.

Guest speakers included Dr. Robert H. Barter, Associate Professor of Obstetrics and Gynecology at the George Washington University School of Medicine, Washington, D. C.; Dr. Herbert D. Kerman, Daytona Beach, Consultant, Medical Division, Oak Ridge Institute of Nuclear Studies; Dr. Jack D. Myers, Professor of Medicine, University of Pittsburgh School of Medicine, Pittsburgh, Pa., and Dr. John T. Reynolds, Associate Professor of Surgery, University of Illinois College of Medicine, Chicago.

The meeting was begun with surgical clinics and a closed circuit television program originating at Orange Memorial Hospital. The program for the clinics included "Cholecystectomy," Dr. Harry H. Ferran; "Pedicle Graft," Dr. Joseph E. O'Malley; and "Vaginal Hysterectomy with Anterior and Posterior Repair," Dr. Chas. J. Collins. Drs. Ferran, O'Malley and Collins are from Orlando.

Following, Dr. James A. McLeod, Orlando, presented the film "Pancreatico-Duodenectomy" as a cine clinic in the San Juan Hotel, headquarters for the meeting.

The program then was given over to the guest speakers. Dr. Barter discussed "Minor and Office Gynecological Procedures;" Dr. Kerman, "The Clinical Status of Radioactive Isotopes;" Dr. Myers, "The Problem of Portal Hypertension," and Dr. Reynolds, "Obstructive or Surgical Jaundice."

Dr. Frank J. Pyle, president of the Orange County Medical Society, gave the address of welcome, and Dr. Oscar W. Freeman, Orlando, served as chairman of the Committee on Arrangements for the meeting.

The Sound-color film "Urine Sugar Analysis for Diabetics" developed in cooperation with the medical profession is available from the Ames Co., Inc., Elkhart, Ind.

It was prepared for use in the education of diabetic patients and shows the relationship between carbohydrates and insulin. It also explains the meaning of various diabetic conditions. The running time is approximately ten minutes.

Physicians may obtain the film through their local Ames representative.

Dr. Eugene Kellersberger of Melbourne was one of 12 Washington University alumni honored at the recent Founders' Day observance for "outstanding achievements and services which have reflected honor upon the University." Dr. Kellersberger, general secretary of the American Mission to Lepers, is the author of the reports on sleeping sickness which form the basic text for the study of this disease in medical schools.

Dr. Clyde O. Anderson of St. Petersburg has been selected to receive a distinguished alumni award from the University of Florida in recognition of his service to his community, his profession and to the alumni association. The award is to be presented Dr. Anderson at the June Commencement.

The Ninth Postgraduate Assembly in Endocrinology and Metabolism has been scheduled for October 21-25 at Augusta, Ga. The Assembly is sponsored by The Endocrine Society, The Medical

(Continued on page 1138)

CALIFORNIA CAREER OPPORTUNITIES FOR PHYSICIANS AND PSYCHIATRISTS. Employment available as a result of interview *only*. Assignments in State hospitals, juvenile and adult correctional facilities, or a veterans home. Three salary groups: $10,860-12,000; $11,400-12,600; $12,600-13,800. Salary increases being considered effective July 1957. Citizenship, possession of, or eligibility for California license required. Write Medical Recruitment Unit, Box A, State Personnel Board, 801 Capitol Avenue, Sacramento 14, California.

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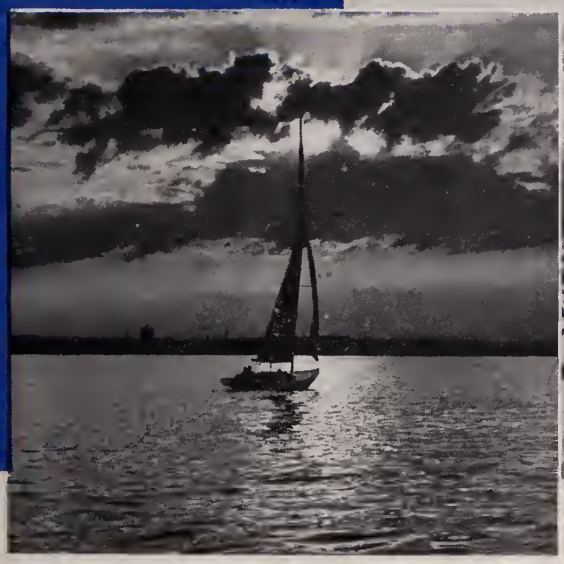

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Hyoscyamine Sulfate.....0.1037 mg.
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Each Extentab (equivalent to 3 Tablets) provides sustained 1-tablet effects...evenly, for 10 to 12 hours—all day or all night on a single dose.

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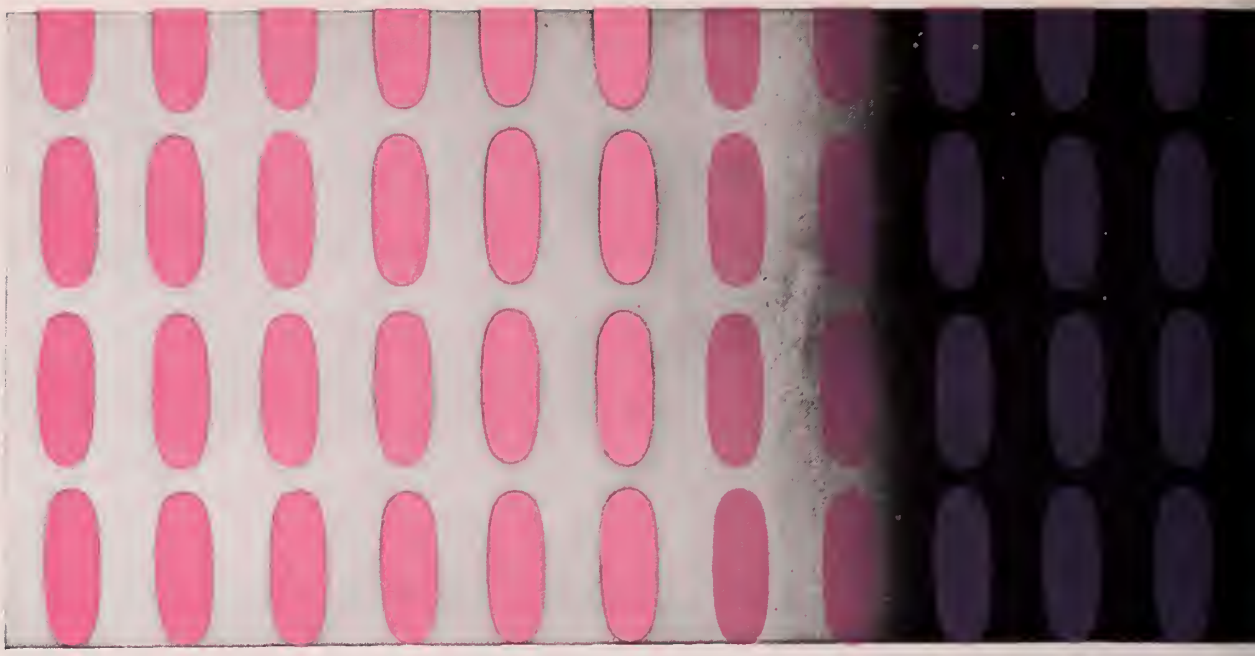
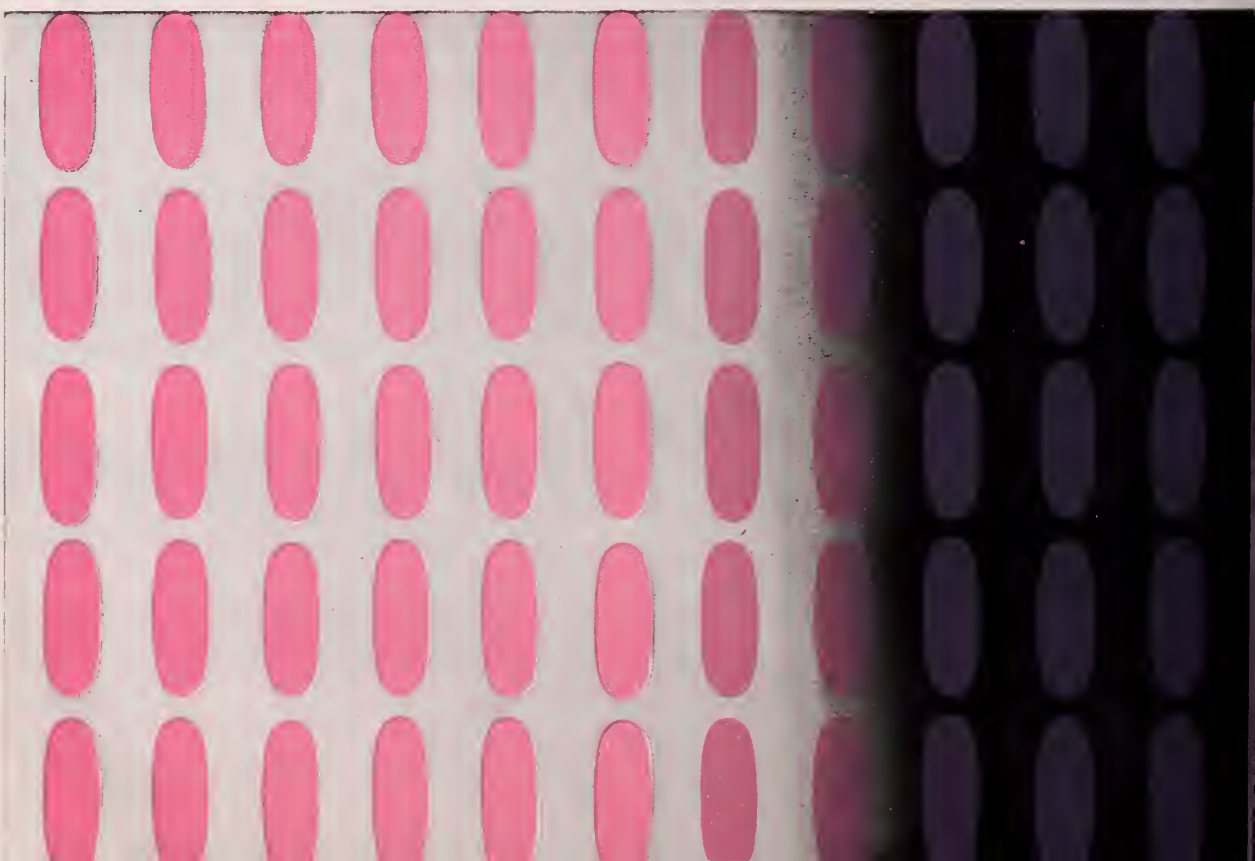


NEW ACHROMY

TETRA



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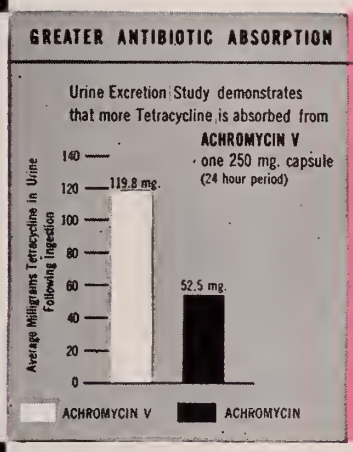

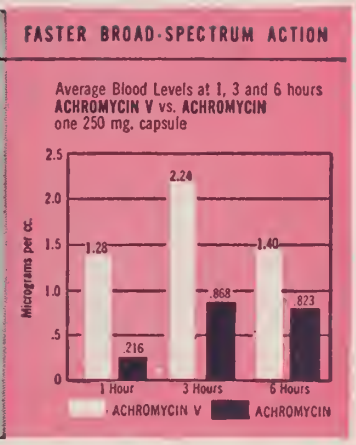

ACHROMYCIN V admixes sodium metaphosphate with tetracycline. ACHROMYCIN V provides greater antibiotic absorption/faster broad-spectrum action and is indicated for the prompt control of infections, seen in everyday practice, hitherto treated with other broad-spectrum antibiotics.

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Tetracycline equivalent to tetracycline HCl.. 250 mg.

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ACHROMYCIN V dosage: 6-7 mg. per lb. of body weight per day for children and adults.

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(Continued from page 1134)

College of Georgia and The Medical College of Georgia Foundation.

The faculty will consist of 22 eminent clinicians and investigators in the fields of endocrinology and metabolism. The program will cover the various endocrinopathies, with emphasis on the clinical aspects, demonstration of laboratory tests, presentations of cases, and question and answer panel discussions. A syllabus with brief abstracts of lectures will be available to the registrants at the time of the Assembly.

The course has been approved by the American Academy of General Practice for 35 credit hours in Category 1.

For information write to Dr. Robert B. Greenblatt, Department of Endocrinology, Medical College of Georgia, Augusta.

Dr. George T. Harrell Jr. of Gainesville, Dean of the University of Florida College of Medicine, has been named "Man of the Year" by the student newspaper, The Alligator.

Dr. Alvan G. Foraker of Jacksonville has been appointed a member of the Advisory Cytology Committee of the Inter-Society Cytology Council by Dr. George N. Papanicolaou. The Committee, composed of cytologists from various parts of the country, is to plan and encourage research in cytology, and more efficient organization of laboratories engaged in cytologic diagnosis.

The Department of Otolaryngology, University of Illinois College of Medicine, has announced its Annual Assembly in Otolarngology to be held September 30 through October 6. The program will consist of an intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to surgical anatomy of the head and neck and histopathology of the ear, nose and throat.

Interested physicians should write direct to the Department of Otolaryngology, 1853 West Polk St., Chicago 12, Ill.

Dr. Seymour L. Alterman of Miami Beach has been certified by the American Board of Internal Medicine.

Dr. Lucien Y. Dyrenforth of Jacksonville has been elected president of the Atlantic Coast Line Railroad Surgeons Association.

no lagging appetites with INCREMIN*

LYSINE-VITAMIN SUPPLEMENT LEDERLE

Finicky eaters are headed for a fast nutritional build-up with Incremin — tasty appetite stimulant.

Incremin offers l-Lysine for improved protein utilization, and essential vitamins for their stimulating effect on appetite.

Tasty Incremin is available in either Drops or Tablets. Caramel-flavored Tablets may be orally dissolved, chewed or swallowed. Cherry-flavored Drops may be mixed with milk, formula or other liquid. Tablets: bottles of 30. Drops: plastic dropper-type bottle of 15 cc.

Each Incremin Tablet
or each cc. of Incremin Drops *contains:*

l-Lysine	300 mg.	Pyridoxine (B_6)	5 mg.
Vitamin B_{12}	25 mcgm.	(Incremin Drops contain 1% alcohol)	
Thiamine (B_1)	10 mg.		

Dosage: only 1 Incremin Tablet or 10-20 Incremin Drops daily.

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The Sixth Annual Symposium for General Practitioners on tuberculosis and other chronic pulmonary diseases will be held in Saranac Lake, N. Y., July 8-12. It is approved for 26 hours of formal credit to members of the American Academy of General Practice. The registration fee is $40. Information and a copy of the program may be obtained from Dr. Henry W. Leetch, general chairman, Symposium for General Practitioners, P. O. Box 11, Saranac Lake, N. Y.

Dr. Hawley H. Seiler of Tampa announces the removal of his office to 517 Bayshore Boulevard, Tampa.

Dr. Frederick D. Droege of Sarasota discussed "The Importance of Allergy to the Otolaryngologist" at a meeting of the American College of Allergists held recently at Chicago.

Dr. Louis L. Amato of Fort Lauderdale has announced that the Fort Lauderdale Beach Hospital will admit its first patients on May 15. Facilities in the 100 bed institution have been keyed to the care of the chronically ill. Departments include radiology, dietetics, dentistry and occupational and physical therapy. An advertisement of the hospital is published in this issue of The Journal.

The Twenty-Third Annual Meeting of the American College of Chest Physicians will be held at the Hotel Commodore, New York City, May 29-June 2. The scientific program will include prominent speakers on all aspects of heart and lung diseases. In addition there will be a number of symposia, round table luncheon discussions, seminars and motion pictures.

A full day Cardiovascular Seminar is being held at Tampa, May 18 sponsored by the Hillsborough County Heart Association. Sessions begin at 9:00 a.m. and will be held in the Tampa Terrace Hotel. Participants include Drs. W. C. Sealy and Edward Orgain, of Duke University Hospital, Durham, N. C., and Dr. Michael DeBakey, Baylor University College of Medicine, Houston, Texas. There is no registration fee.

Dr. Hawley H. Seiler of Tampa participated in the recent 25th Annual Assembly of the Southeastern Surgical Congress held at St. Petersburg. The title of his presentation was "The Surgical Treatment of Pectus Excavatum."

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The reduced incidence of side actions with PRELUDIN makes losing weight more comfortable for the average patient, facilitates treatment of the complicated case and frequently permits its use where other anorexiants are not tolerated.[3]

Recommended Dosage: One tablet two to three times daily one hour before meals. Occasionally smaller dosage suffices. On theoretical grounds, PRELUDIN should not be given to patients with severe hypertension, thyrotoxicosis or acute coronary disease.

(1) Holt, J. O. S., Jr.: Dallas Med. J. *42*:497, 1956. (2) Gelvin, E. P.; McGavack, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. *1*:155, 1956. (3) Natenshon, A. L.: Am. Pract. & Digest Treat. *7*:1456, 1956.

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In order to satisfy these extremely high nutritional requirements, "protective" foods supplying liberal amounts of protein, vitamins, and minerals should predominate in adolescent diets.[3] Such foods include meat, poultry, fish, milk, eggs, vegetables and fruits, and whole-grain or enriched cereals and enriched bread. Accessory foods commonly eaten by adolescents to satisfy emotional needs may provide energy, but are commonly responsible for obesity and should not take the place of the "protective" foods.

Meat contributes much toward making the daily meals of adolescents appetizing, ample, and satisfying as well as adequate in protein, B vitamins, iron, phosphorus, potassium, and magnesium. Its complete protein functions in all physiologic mechanisms utilizing protein—tissue growth and replacement, fabrication of enzymes, hormones, and antibodies, and maintenance of the body's fluid balance. Its B vitamins and minerals take part in many processes of intermediate metabolism important in body development.

1. Toverud, K. U.; Stearns, G., and Macy, I. G.: Maternal Nutrition and Child Health. An Interpretative Review, Washington, D.C., National Research Council, National Academy of Sciences, Bull. No. 123, 1950, p. 115.
2. Proudfit, F. T., and Robinson, C. H.: Nutrition and Diet Therapy, ed. 11, New York, The Macmillan Company, 1955, p. 271.
3. Martin, E. A.: Roberts' Nutrition Work with Children, Chicago, The University of Chicago Press, 1954, pp. 231-236.

The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

COMPONENT SOCIETY NOTES

Dade

National Medical Education Week was observed by the Dade County Medical Association with a program for the April meeting presented by the faculty of the University of Miami School of Medicine. The program was under the direction of Dr. Homer F. Marsh, Dean of the School of Medicine.

Duval

Dr. Samuel Proger, Physician-in-Chief at Pratt Diagnostic Clinic, Boston, and also Professor of Medicine at Tufts College Medical School, Boston, was principal speaker for the April meeting of the Duval County Medical Society. Dr. Proger discussed cardiac diseases with references to the doctor and the personal care of himself as it relates to cardiovascular diseases.

The program was under the direction of the Northeast Florida Heart Association. Invited guests were members of the county medical societies near Duval.

Hillsborough

Dr. Leo G. Rigler, Professor of Radiology at the University of Minnesota Medical School, Minneapolis, was principal speaker for the April meeting of the Hillsborough County Medical Association. The title of Dr. Rigler's address was "Roentgen Diagnosis of Heart Disease."

Jackson-Calhoun

The Jackson-Calhoun County Medical Society has paid 100 per cent of its state dues for 1957.

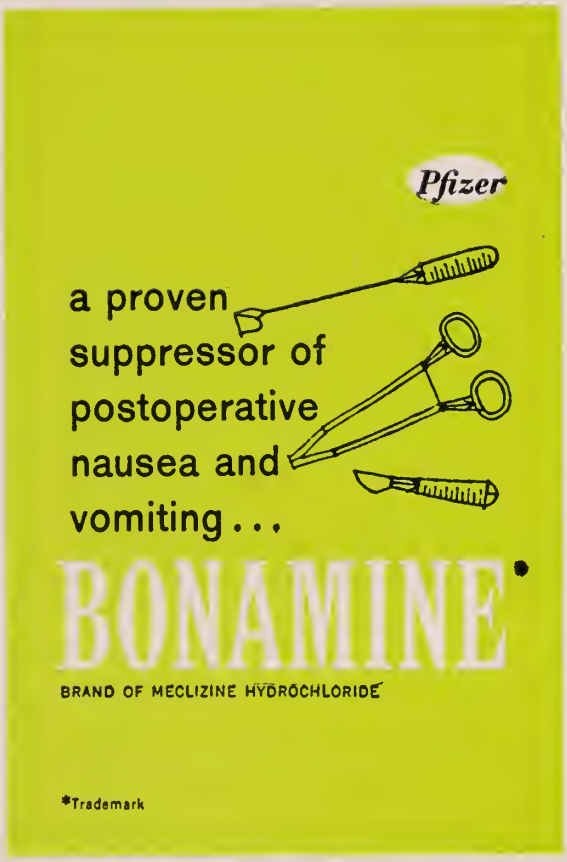
Dr. and Mrs. Jasper B. Dowling were hosts to the recent regular quarterly meeting of the Society in their home at Alliance. Members of the Woman's Auxiliary met jointly with the Society.

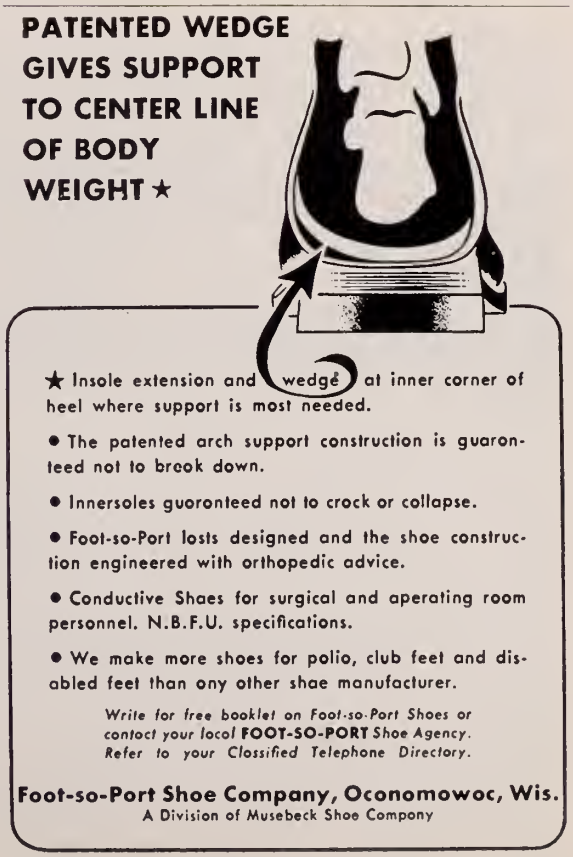
Lake

The March meeting of the Lake County Medical Society was held at Howey-in-the-Hills. Dr. John D. Bloom, Groveland, was program chairman and presented Dr. Lorant Forizs, Chief Psychiatrist at the Alcoholic Rehabilitation Center, Avon Park, and Dr. Hubert W. Coleman, also from Avon Park. Drs. Forizs and Coleman discussed chronic alcoholism and present day methods of management.

Pinellas

Dr. Louis H. Clerf was principal speaker at the April meeting of the Pinellas County Medical Society held at Madeira Beach. The title of his address was "History of Foreign Bodies in the Ear and Oral Passages."





Medical Licenses Granted

Dr. Homer L. Pearson Jr., secretary of the State Board of Medical Examiners, has reported that of the 314 applicants who took the examination of the Board, held November 25, 26, and 27, 1956, in Miami Beach, 222 passed and have been issued licenses to practice medicine in Florida. The names and addresses of the 222 successful applicants follow:

Adams, Charles Baird Jr., Miami (U Maryland 1952)
Aitelli, Ernest Charles Gregory, Newark, N. J. (Columbia 1948)
Albert, Harold Franklin, Miami (Geo. Washington 1954)
Allison, Ronald Eugene, Hollywood (Duke 1956)
Alper, Louis, Miami, (Wayne 1940)
Avant, Earl Stanley, Charleston, S. C. (South Carolina 1955)
Aye, Ralph Claxton, Evanston, Ill. (Geo. Washington 1950)
Azen, Norman Hillard, Lantana (U Pittsburgh 1952)
Banks, Keith Duane, Knoxville, Iowa (U Iowa 1951)
Becker, David Jerome, Miami (Harvard 1955)
Behr, Donald Jay, Brooklyn (Chicago 1953)
Berley, Ferdinand Victor, Jacksonville (Northwestern 1939)
Beychok, Irving Abraham, Lafayette, La. (Louisiana State 1949)
Bosniak, Morton Arthur, East Rockaway, N. Y. (New York U 1955)
Boyd, Eugene Judd, Dearborn, Mich. (U Iowa 1939)
Breslar, Elliott I., Miami Beach (Chicago 1956)
Carter, Howard Wesley, St. Petersburg (Queens 1933)
Cayia, Edward deRosier, Fort Lauderdale (Loyola 1948)
Cella, Charles Francis, Trenton, N. J. (Bellevue 1931)
Center, Sol, St. Louis (U Minnesota 1950)
Chapman, William Phalen, Boston (McGill 1938)
Cheslock, William Bernard, Key West (Jefferson 1954)
Chew, William, Orlando (S. E. Med. College, China 1941)
Chrysler, Charles Otis, Miami (Ohio State 1956)
Clayton, Orville Woolford, Birmingham, Ala. (Northwestern 1946)
Clevenger, Charles Edward, Miami (U Alabama 1956)
Clinton, Dale Leonard, Lakeland (U Kansas 1954)
Cobb, Sanford, Coral Gables (Albany 1951)
Cole, Walter Allen Jr., Jacksonville (U Louisville 1956)
Conlan, James Kenneth, Harlan, Ky. (U Louisville 1945)
Converse, John Gerard, Miami (Tufts 1943)
Cooper, Charles David, Alexandria, Va. (Geo. Washington 1951)
Cornett, Eugene Jones, Tampa (Duke 1949)
Costanza, Louis Carmine, Philadelphia (Jefferson 1952)
Covalt, Nila Kirkpatrick, Winter Park (Indiana 1933)
Crawford, John Patrick, Columbus, Ohio (Ohio State 1949)
Crumpacker, Edgar Lee, White Sulphur Springs, W. Va. (U Virginia 1942)
Culbertson, Eugene Carl, Pennington Gap, Va. (U Virginia 1955)
Damsey, Lloyd, Miami (U Buffalo 1955)
Daniel, Kearney Buell Jr., Miami (U Louisville 1956)
Davis, Donald James, Dedham, Mass. (Boston 1951)
Davis, Joseph Harrison, Miami (Long Island 1949)
Dayton, John Thomas, Miami (Ohio State 1956)
Dean, Harry Brooks, Norristown, Pa. (U Georgia 1944)
DeCenzo, Joseph Anthony, Miami (U Pittsburgh 1955)
deCiutiis, Vincent Louis, New York (New York 1948)
de Olazarra, Allen Charles, Coral Gables (U Illinois 1952)
de Victoria, William L., Miami Beach (Georgetown 1956)
Dobbrunz, Harry Curt, Hollywood (U Illinois 1955)
Dolce, Joseph Rocco, Buffalo (U. Buffalo 1931)
Duff, Roland DeWitt, Birmingham, Ala. (Alabama 1956)
Durlacher, Stanley Henry, Coral Gables (Yale 1938)
Edelstein, Jack Paul, Miami Beach (U Chicago 1956)
Edlund, Richard Allan, Miami (U Minnesota 1956)
Epes, Freeman, Atlanta, Ga. (Virginia 1956)

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Unique physiologic barrier—topical amino acids—brings rapid relief (98%[1]) and complete healing (88%[1])

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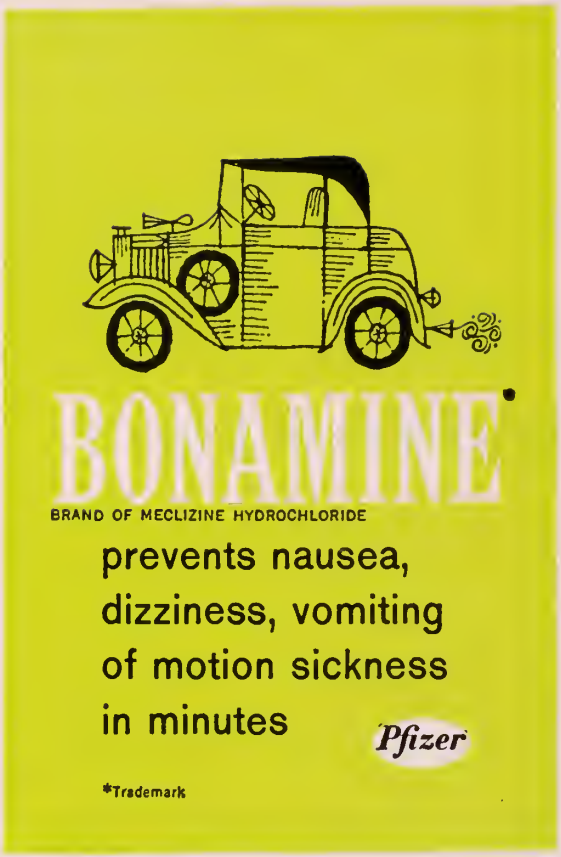
1. Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, Am. J. Digest. Dis. 18:59 (Feb.) 1951.
2. Fromer, J.L.: Dermatologic Concepts and Management of Pruritus Ani, Am. J. Surg. 90:805 (Nov.) 1955.



Epps, Earle William, Staten Island, N. Y. (Albany 1950)
Eveloff, Herbert Hyman, Miami Beach (Temple 1956)
Faaland, Halvdan Gerhard Keyser, Jacksonville (Long Island 1943)
Faber, John Hubert, Gloversville, N. Y. (New York 1942)
Feuerman, Martin Norman, Miami Beach (New York 1956)
Fischbach, Karl, New York (U & Bellevue Hospital 1932)
Foertsch, Frederick Edward Jr., Dearborn, Mich. (Temple 1942)
Frankel George Jay, New York (Columbia 1950)
Gastring, Joseph Bennett, Yoakum, Texas (Baylor 1952)
Gevas, George, Baltimore (U Maryland 1953)
Gibby, John Francis, Miami (Geo. Washington 1954)
Gibson, Thomas Ashford, Huntsville, Ala. (Emory 1955)
Gilmore, Hugh Richmond III, Miami (U Pa. 1950)
Gladson, Noel Richard, Jacksonville (Javeriana 1950)
Goldman, Morris Eli, Hollywood (Tufts 1928)
Graden, Earl Alvin, East Point, Ga. (Temple 1953)
Graff, Harry Walter, Miami (U Illinois 1956)
Greenberg, Sigmund Robert, Philadelphia (Hahnemann 1956)
Griffin, Joseph Edward, Buffalo (U Buffalo 1949)
Grim, Kenneth Boyd, Charlottesville, Va. (U Virginia 1937)
Grogan, Robert Edward, West Palm Beach (U Louisville 1956)
Haeck, Alfons Josef, Orlando (U Bonn 1936)
Hale, Alfred Reece, New Orleans (Tulane 1956)
Halpern, Arthur Elliot, Miami (New York State 1954)
Hamilton, Catherine Latane, Augusta, Ga. (Women's M. C. of Pa. 1955)
Hanson, Eugene William, St. Petersburg (U Minnesota 1956)
Hartman, Howard Ernest, St. Louis (St. Louis 1951)
Hatton, Robert Lester, Miami (Tulane 1956)
Hess, Robert William, Miami (Tulane 1955)
Hieber, Robert Daniel, St. Petersburg (U Pittsburgh 1955)
Hill, Harold Donald, Jacksonville (U Virginia 1954)
Hoffman, William Henry, Charlottesville, Va. (Albany 1953)
Holley, John Calvert Jr., Jacksonville (Geo. Washington 1956)
Hoover, Richard Davis, Emory University, Ga. (U Oklahoma 1954)
Hopen, Joseph Martin, Miami (Jefferson 1949)
Horn, Paul Caughman, Miami (Jefferson 1956)
Hughes, Dixon Lee, North Miami Beach (Indiana 1954)
Hutchinson, William Mostyn, Jacksonville (Hahnemann 1948)
Hutson, Joe Darrel, Detroit (U Tenn. 1951)
Izumi, Ernest Matson, St. Petersburg (S. W. Div. U Texas 1950)
Jacobs, Walter Harvey, Brooklyn (Chicago 1954)
Jaffe, Robert Jay, Brooklyn (Hahnemann 1953)
Janulis, Alexander Theodore, Maplewood, N. J. (New York 1953)
Johnson, Hugh Wendell, Bradenton (U Tenn. 1956)
Jorgensen, Niels Bjorn Jr., North Hollywood, Calif. (Evangelists 1955)
Kantor, Norman, Miami (U Oklahoma 1955)
Kassels, Sidney Victor, Walnut Creek, Calif. (Middlesex 1943)
Kates, Matthew Forest (Col.), Fort Lauderdale, (Evangelists 1954)
Kaye, Bernard Louis, Savannah, Ga. (Harvard 1955)
Kelemen, William Arthur, Maple Heights, Ohio (Ohio State 1950)
Kellogg, Cal Stewart, Miami (Western Reserve 1946)
Kilgo, Frank DeWald, Columbus, Ga. (Emory 1955)
Kirker, Walter Robert, Key West (Temple 1954)
Koenig, James William, Tampa, (Ohio State 1954)
Lambert, Walter Renato, Daytona Beach (U Havana 1948)
Latty, Samuel George, Orlando (Duke 1949)
Lehman, John Ditter, Miami, (U Iowa 1956)
Lipton, Alan Alvin, New Orleans (Tulane 1951)
Lipton, Roger Andrew, Brooklyn (Syracuse 1932)
Litt, Richard Erwin, Miami (Alabama 1956)

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1. The Food Exchange Lists referred to are based on material in "Meal Planning with Exchange Lists" prepared by Committees of the American Diabetes Association, Inc., and The American Dietetic Association in cooperation with the Chronic Disease Program, Public Health Service, Department of Health, Education and Welfare.

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Your Name and Address

Loukota, James Ernest, West Palm Beach (U Nebraska 1956)
MacCollum, Maxwell Speers, Indianapolis (Indiana 1956)
Magill, John Charles, St. Petersburg (Ohio State 1954)
Mahan, John William, Cincinnati (Northwestern 1951)
Mahon, Chester Wadsworth Jr., Tampa (Temple 1956)
Maren, Thomas Hartley, Gainesville (Johns Hopkins 1951)
Marks, Asher, Miami (Emory 1950)
Marquardt, Robert George, St. Petersburg (Cornell 1943)
Marquez, Antonio Higinio, Miami (U Havana 1950)
Masten, Mabel Garden, Miami (U Chicago 1925)
Mazursky, Milton Michael, Miami (New York 1945)
McConnell, Bright Jr., Augusta, Ga. (Georgia 1950)
McCrocklin, Kenneth Haller, Louisville, Ky. (U Louisville 1950)
McGrady, Charles Winfred Jr., Miami (U Maryland 1951)
Medow, Aaron, Miami Beach (Hahnemann 1956)
Mendenhall, Charles Lee, Columbus, Ga. (U Nebraska
Miller, Robert Allen, Coral Gables (Geo. Washington 1956)
Miller, William Henry Jr., Orlando (U Pittsburgh 1943) 1956)
Mitnick, Stanley Marvin, Miami Beach (Hahnemann 1956)
Molina, Antonio Eduardo, Miami (Hahnemann 1943)
Montgomery, Charles Ellsworth, Roswell, N. M. (U Kansas 1944)
Morgan, Leslie Aaron, Miami (U Louisville 1955)
Morgan, Philander Dean, Birmingham, Ala. (Alabama 1950)
Mozen, Herschel Eugene, Euclid, Ohio (Western Reserve 1949)
Murphy, William Parry Jr., Miami (U Illinois 1947)
Nassef, George Joseph, West Palm Beach (Jefferson 1948)
Needell, Stanley Stuart, Miami (U Virginia 1956)
Newbill, Cannon Erby Jr., Jacksonville (U Tenn. 1955)
Newhall, Joseph Frank Paul Jr., Winter Park (Tulane 1955)
Norris, Franklin Gray, Winston-Salem, N.C. (Harvard 1951)
Orlick, Abraham Pierpont, Miami Beach (Long Island 1922)
Overman, Robert Lee, Pensacola (Temple 1950)
Palmieri, Anthony Gerard, Shaker Heights, Ohio (St. Louis 1937)
Palmisano, Peter John, Ben's Lake, Eglin AFB, (U Vermont 1954)
Paloucek, Frank Paul, McHenry, Ill. (U Illinois 1947)
Parker, James William, Bartow (U Oklahoma 1946)
Parsons, Robert Lee, Orlando (Tulane 1955)
Pasternack, Frederick Oliver, Miami (Columbia 1956)
Peck, Earl Masters, Key Biscayne (Virginia 1937)
Perkoff, Morton William, Collingswood, N. J. (Hahnemann 1955)
Perry, James Boyce, St. Petersburg (Marquette 1956)
Petkas, Nicholas Steven, Fort Bragg, N.C. (Emory 1954)
Pippin, Earl Cranston Jr., Tampa (U Tenn. 1953)
Piver, Julius Samuel, Washington, D. C. (Geo. Washington 1952)
Plum, George Elwood, Rochester, Minn. (Harvard 1951)
Podis, Alan David, Cleveland, Ohio (Western Reserve 1956)
Poske, Robert Martin, Hines, Ill. (Northwestern 1948)
Provo, Wilford Morris, Tampa (U Tenn. 1956)
Ptomey, William Reagan, Century (Tulane 1956)
Rawlings, Frederick Painter Jr., Winter Haven (Vanderbilt 1944)
Raynak, Frank Raymond, Rochester, Minn. (Temple 1947)
Reynolds, Georgia, Plantation (U Maryland 1951)
Rhodes, Jordan Maynard, Chicago (Chicago 1955)
Robinson, Alan Saul, Jamaica, N.Y. (Cornell 1950)
Rodenberg, Thomas Alfred, Buffalo (U Buffalo 1951)
Rosenstein, Ira Nathaniel, Miami Beach (New York 1956)
Russell, Anne Patras, Miami (Loyola 1941)
Russell, Theodore Albert, Cleveland (Western Reserve 1956)

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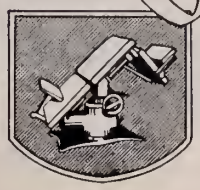

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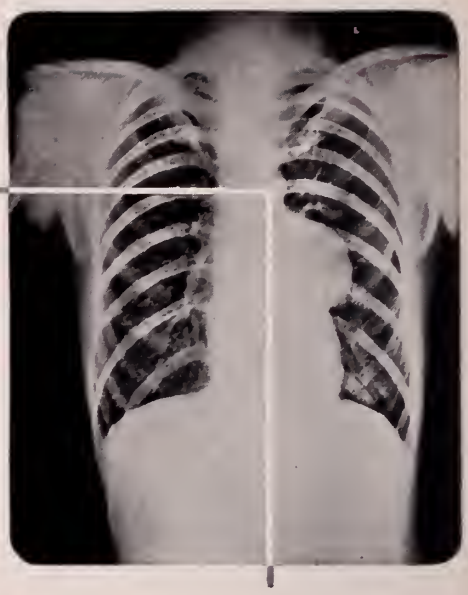

You might suppose a good chest film would be easy to take. Yet this "simple" examination is often very troublesome. The trick is to get consistent *uniformity* so films of a given patient taken at long intervals will always be dependably comparable in density and contrast. If you're an expert technician, you juggle kilovoltage, time, milliamperage and focal spot to suit each patient. If you're not, you guess . . . *wrong*, too often.

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to the measured thickness of the part

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Salina, Richard James, Fort Walton Beach (U Pittsburg 1954)
Schatzki, Peter Ferdinand, Bristol, Conn. (Tufts 1952)
Schleifer, Donald Muskat, Chicago (U Illinois 1953)
Schroer, Harry August, Lantana (Cornell 1945)
Schultz, Gerald Ted, St. Petersburg (U Iowa 1956)
Schultz, Lester Jacob, New York (U Lausanne 1942)
Scott, Edwin Paul, Venice (U Louisville 1940)
Seda-Morales, Ruben, Bradenton (Hahnemann 1946)
Segal, Myron Irving, Miami Beach (McGill 1949)
Serrano, Mario Edward, New Orleans (Tulane 1956)
Sher, David Daniel, North Miami Beach, (Boston 1934)
Sherman, Charles Russell, Arabi, La. (Tulane 1942)
Sherrill, Robert Grady Jr., Lakeland (U Tenn, 1955)
Shuttleworth, John Elmer Samuel, Clearwater (Hahnemann 1944)
Sigal, Howard Marvin, Akron, Ohio (Ohio State 1954)
Silver, Bernd, Miami (U Louisville 1956)
Smith, George Franklin, Miami (Georgetown 1953)
Smith, Richard Lee, Miami (U Cincinnati 1953)
Smith, Stuart Cameron, DeLand (Duke 1947)
Sneider, Stanley Eugene, Laurelton, N.Y. (New York 1955)
Soma, Edward David, Miami (Georgetown 1956)
Sommer, Leonard Samuel, Miami (Columbia 1947)
Speed, Louis Elliott, Shawnee, Okla. (Vanderbilt 1951)
Spindell, Edward, Rantoul, Ill. (Boston 1953)
Stephenson, Charles Martin, Miami (Evangelists 1956)
Szawlowski, Matthew Walter, Miami (U Buffalo 1956)
Terris, Gerald, Miami (Boston 1952)
Thabit, George Jr., Opa Locka (Tulane 1955)
Thompson, Jasper Fritz III, Martinsburg, W. Va. (Emory 1955)
Thompson, Oscar William Jr., Ellington AFB, Texas (U Louisville 1955)
Thompson, William West, Eglin AFB, (Duke 1947)
Tocci, Frank Paul, Montclair, N.J. (Hahnemann 1940)
Torres, Joseph, Jacksonville (Georgetown 1955)
Travis, Burton Lester, New York (Duke 1952)
Trombley, Joseph Jerome Jr., Detroit (U Michigan 1925)
Turner, Thomas Alexander, Orlando (Tufts 1953)
Van Alstyne, Walter Kent, St. Petersburg (Albany 1926)
Waldheim, Hugo Jr., Birmingham, Ala. (Alabama 1956)
Walls, Fred Jr., Richmond, Va. (Virginia 1947)
Watson, Hugh Alfred, Greensboro, N.C. (Virginia 1930)
Webb, Edgar William, Dearborn, Mich. (Marquette 1951)
Weiner, Harold Henry, Eatontown, N.J. (Kansas City 1941)
Weisman, Joseph Charles, Kew Gardens, N.Y. (Geo. Washington 1930)
Wendland, Robert Paul, Elgin, Ill. (Northwestern 1950)
White, Grover Watts, Jacksonville (Alabama 1956)
White, Joseph William, Fort Lauderdale (Jefferson 1926)
Whitehurst, William Laney, Jacksonville (U Tenn. 1934)
Williams, Robert Murray, Miami (Indiana 1956)
Wolf, Robert Lawrence, New York (Duke 1952)

BOOKS RECEIVED

The Philosophy of Medicine. By William R. Laird, M.D. Pp. 64. Price, $3.00. Charleston, West Virginia, Education Foundation, Inc., 1956.

"Every thinking person develops a philosophy of life and conduct," comments the author of this little volume. "Like all physicians I have developed a philosophy of medicine. It has engaged my thinking over all my years of activity and I have discussed it at some length with many successive groups of Surgical Residents. One after another has asked for copies of the notes." In consequence, this philosophy is here set forth in short essays covering the five fields of study that philosophy includes — logic, esthetics, ethics, politics, and metaphysics—all of which have a rightful place in medicine.

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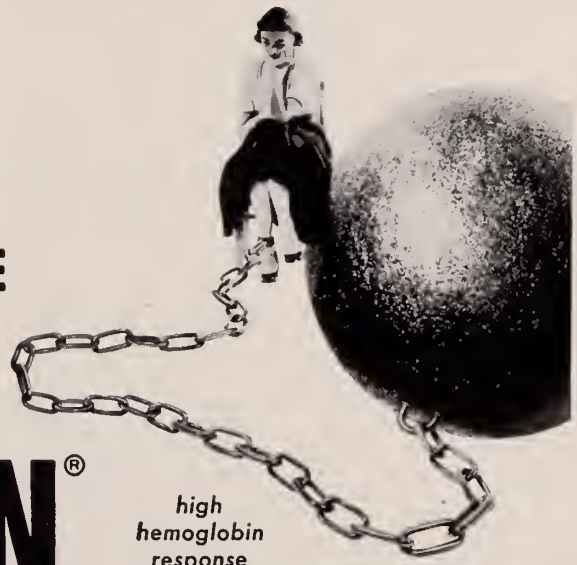

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The older infant weaned from bottle to cup may reject milk or go on a hunger strike. Devoted to his bottle he resents its sudden deprivation. It takes a certain readiness for weaning to make that change agreeable. Later the infant becomes somewhat independent of his mother and arbitrary with his food. What he enjoyed yesterday, he rejects today. If he distorts the diet for a day and his mother resorts to force, a feeding problem is in the making. Sensible decorum will solve these little difficulties before they become big behavior disturbances in childhood.

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Mrs. Perry D. Melvin 1957-58 President Of Auxiliary

At the annual meeting of the Woman's Auxiliary to the Florida Medical Association held at the Hollywood Beach Hotel on May 6, Mrs. Perry D. Melvin was installed as president of the Auxiliary for the 1957-58 term.

Mrs. Melvin, known to all her friends as Judy—short for Judith, was born and reared in New Orleans, La., where she attended school and was graduated from Sophie Newcomb College. While Dr. Melvin was interning in the Panama Canal Zone they were married and later lived in Philadelphia where he was a resident in urology. The Melvins came to Miami in 1940 and have been in that city since that time.

Mrs. Melvin has served as President of the Woman's Auxiliary to the Dade County Medical Association in 1947-48, and in addition in practically every other capacity. She is the Councilor for the Woman's Auxiliary to the Southern Medical Association and previously served two years as Chairman of the Jane Todd Crawford Loan Scholarship Fund Committee for that Auxiliary.

(Continued on page 1158)

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Muscle relaxants			✓1	
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(Continued from page 1153)

She has served the Florida Auxiliary as Chairman of the Jane Todd Crawford Loan Scholarship Fund Committee, and as Chairman of the Yearbook Committee.

The Melvins have four children, Perry D., David, Judy and Laura. Dr. Melvin was originally from Milton, Fla., and they take much of their vacation in the environs of Milton, fishing, swimming, hunting or just being outdoors.

The best wishes of every auxiliary member are extended to Mrs. Melvin for a most successful and happy year as President.

Installation ceremonies were conducted by Mrs. Robert Flanders, President, Woman's Auxiliary to the American Medical Association.

The chairmen of standing and special committees selected by Mrs. Melvin were announced at the annual meeting and they attended the school of instruction and postannual board meeting held the morning of Tuesday, May 7, followed by a luncheon for all board members and others.

Although the administration of the Auxiliary changes each year, there is no let up in the continuity of the work for the betterment of health of the people of Florida, and the programs and

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1. Moyer, J.H.: J. Louisiana M. Soc. *108*:231 (July) 1956.

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2. Wright, W.T., Jr., et al.: J. Kansas M. Soc. *57*:410 (July) 1956.

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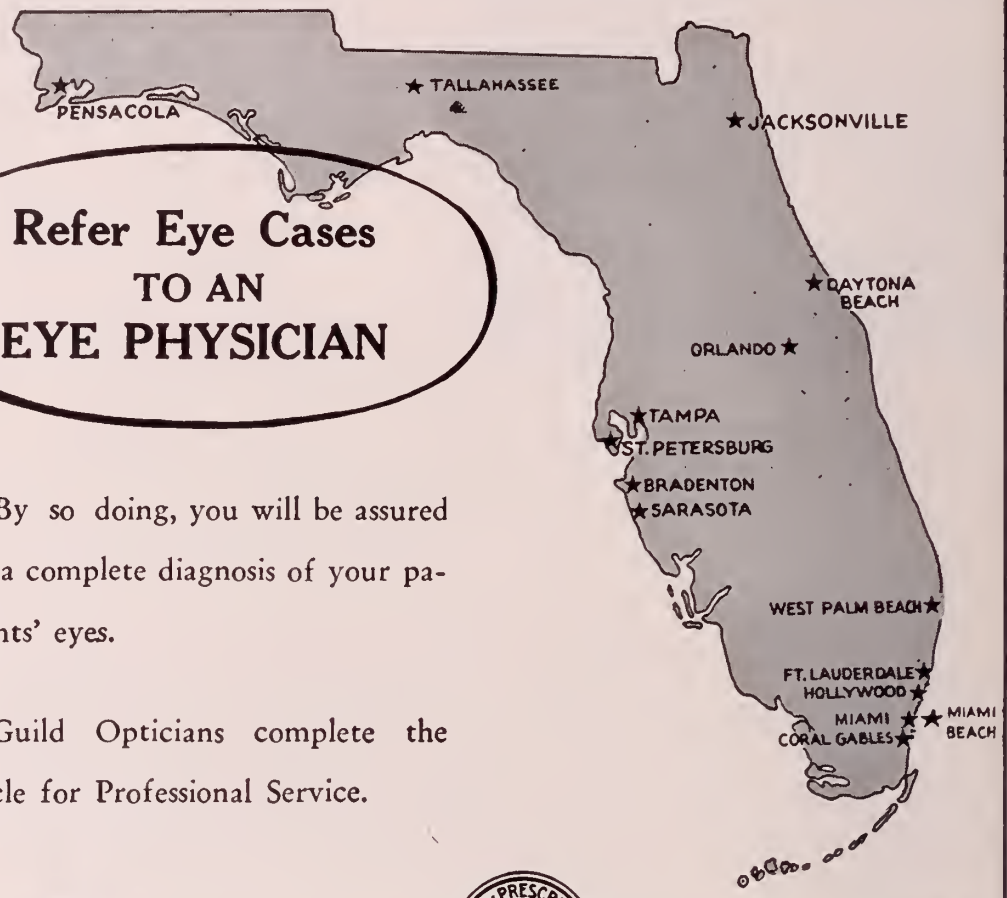

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projects of the Auxiliary. The Auxiliary will continue under Mrs. Melvin to function on a twelve month, 365 day per year basis, each day and each month bringing increased activity, interest and benefits through the work done by the wives of the doctors in Florida.

Good luck, Judy, we hope each day of your administration is one you will treasure in years to come. —Mrs. Richard F. Stover

Proceedings and Index Issues For The Journal

The proceedings of the Eighty-Third Annual Meeting of the Florida Medical Association is scheduled for publication in the July issue of The Journal. The index to Volume XLIII will be published in June, which is the final issue of the current volume.

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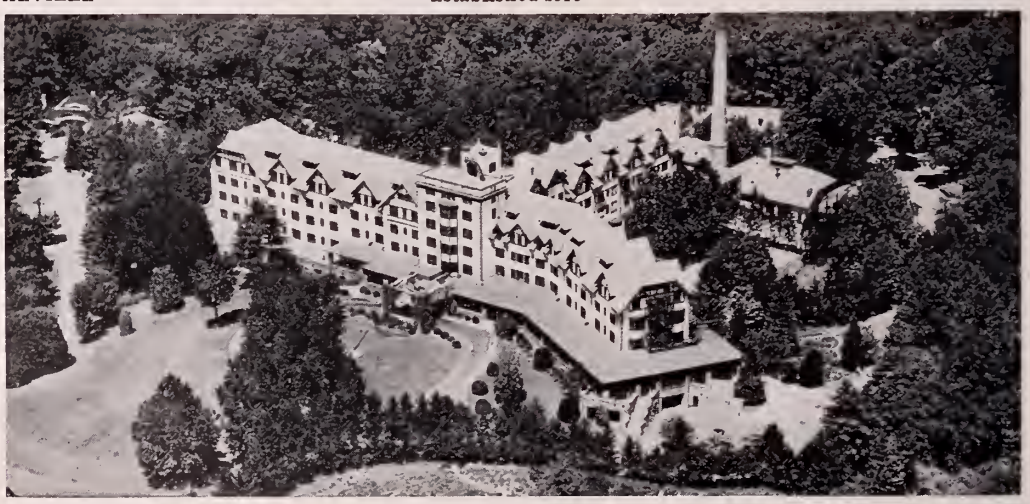

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Brevard	Myron L. Habegger, Rockledge	Louis C. Jensen Jr., Rockledge	2nd Tues.	39
Broward	Walter J. Glenn Jr., Fort Lauderdale	Garland M. Johnson, Fort Lauderdale	4th Tues.	141
Collier	James A. Craig, Naples	Ethel H. Trygstad, Naples	3rd Wed.	9
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Duval	Leo M. Wachtel, Jacksonville	Charles F. McCrory, Jacksonville	1st Tues.	315
***Clay**				
Escambia	Paul F. Baranco, Pensacola	Pascal G. Batson Jr., Pensacola	2nd Tues.	106
***Santa Rosa**				
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Indian River	Walter W. McCorkle, Vero Beach	Enoch J. Vann Jr., Vero Beach	2nd Tues.	9
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***Sumter**				
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Leon-Gadsden-Liberty-Wakulla-Jefferson	George S. Palmer, Tallahassee	Nelson H. Kraeft, Tallahassee	Quarterly	67
Madison	Julian M. DuRant, Madison	A. Franklin Harrison, Madison		6
Manatee	Joseph A. Gibson, Bradenton	Warren G. Darty, Palmetto	2nd Tues.	26
Marion	John D. Lindner, Ocala	Robert L. Gibson, Ocala	3rd Tues.	32
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Orange	Frank J. Pyle, Orlando	W. Ansell Derrick, Orlando	3rd Wed.	200
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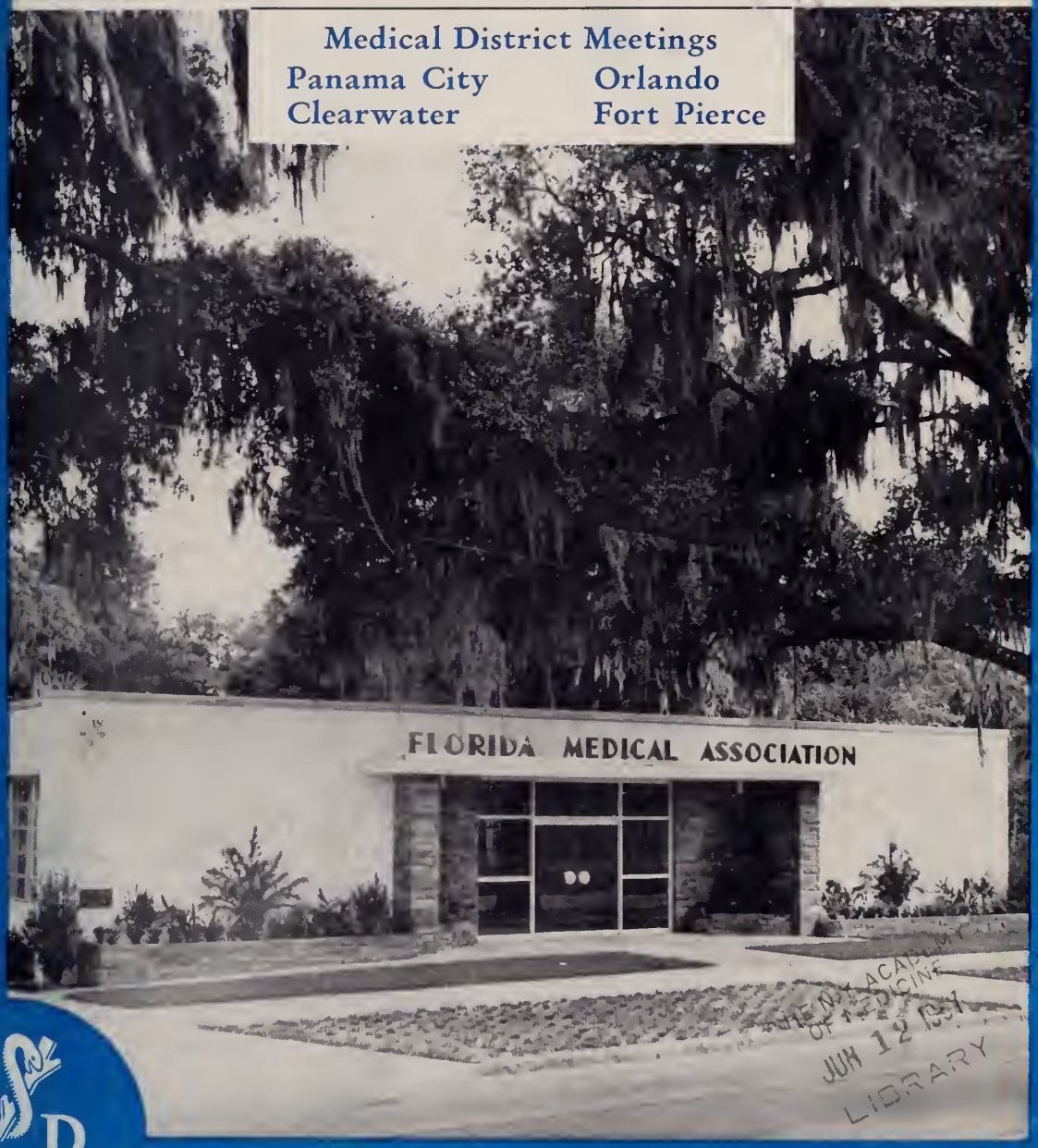

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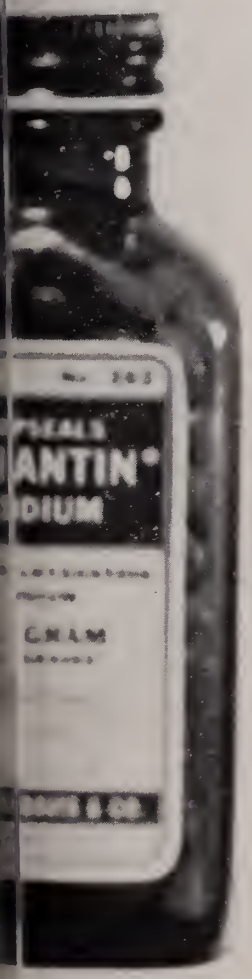

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1. Zimmerman, F. T., and Burgemeister, B.: *Arch. Neurol. & Psychiat.* 72:720, 1954.
2. Zimmerman, F. T., and Burgemeister, B.: *J.A.M.A.* 157:1194, 1955.
3. Zimmerman, F. T.: *Arch. Neurol. & Psychiat.* 76:65, 1956.

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BRAND OF CHLORMERODRIN (16.3 MG. OF 3-CHLOROMERCURI-2-METHOXY-PROPYLUREA EQUIVALENT TO 10 MG. OF NON-IONIC MERCURY IN EACH TABLET)

a standard for initial control of severe failure

MERCUHYDRIN® SODIUM
BRAND OF MERALLURIDE INJECTION

LAKESIDE

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My patients complain that the pain tablets I prescribe are too slow-acting... they usually take about 30 to 40 minutes to work.

Why don't you try the new codeine derivative that's combined with APC for faster, longer-lasting pain relief?

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What is it... how fast does it act?

It's Percodan®—relieves pain in 5 to 15 minutes, with a single dose lasting 6 hours or longer.

How about side effects?

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(dihydroxy aluminum aminoacetate with belladonna alkaloids and phenobarbital)

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It's no wonder that of the many antacid-spasmolytic formulations promoted to the medical profession, so many physicians have found MALGLYN the most consistent in clinical effectiveness.

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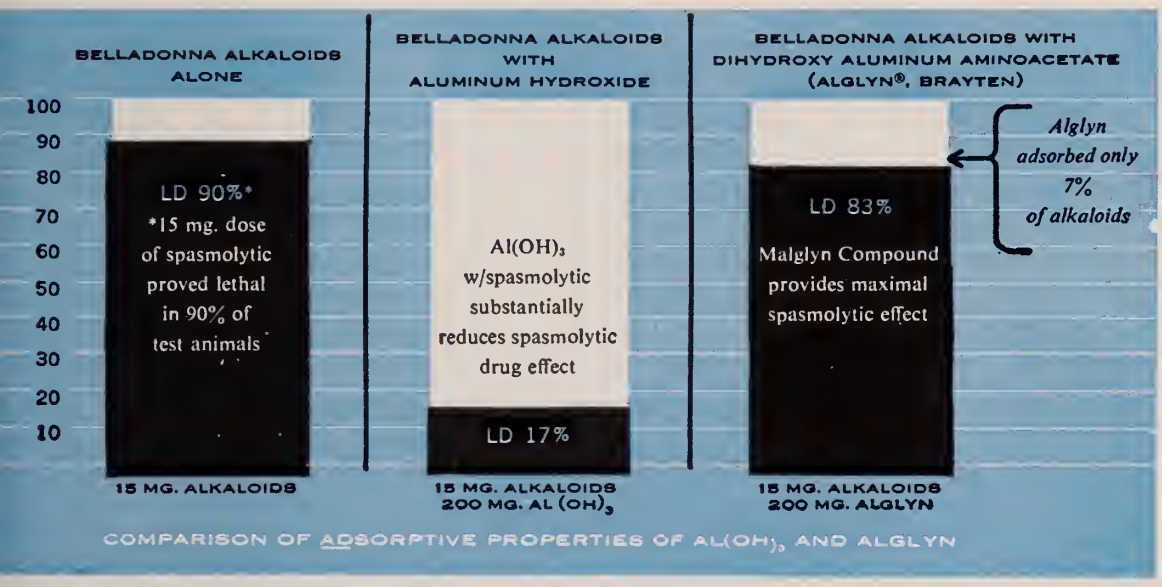

The above laboratory study clearly indicates that the antacid ALGLYN, contained in the MALGLYN formula, does not materially interfere with the therapeutic effectiveness of its contained belladonna alkaloids. On the other hand, the marked *ad*sorptive properties of aluminum hydroxide renders its combination with belladonna alkaloids both uneconomical and therapeutically unreliable.

For both rapid and prolonged antacid effect, with consistently effective spasmolytic and sedative action, rely upon MALGLYN for treatment of peptic ulcer and epigastric distress.

each tablet contains

dihydroxy aluminum aminoacetate, N.N.R.	0.5 GMS
belladonna alkaloids (as sulfates)	0.162 MG.
phenobarbital	16.2 MG.

Also supplied: ALGLYN® (dihydroxy aluminum aminoacetate, N.N.R. 0.5 Gm per tablet). BELGLYN® (dihydroxy aluminum aminoacetate, N.N.R., 0.5 Gm. and belladonna alkaloids, 0.162 mg. per tablet).

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Traumatic periarticular fibrositis is a common penalty for those who go beyond their physical capacity. Early and adequate therapy with SIGMAGEN prevents the development of ligamentous calcification, periarthritis and its painful, sometimes irreversible, results. SIGMAGEN provides doubly protective corticoid-salicylate therapy — a combination of METICORTEN® (prednisone) and acetylsalicylic acid providing additive antirheumatic benefits as well as rapid analgesic effect. These benefits are supported by aluminum hydroxide to counteract excess gastric acidity and by ascorbic acid, the vitamin closely linked to adrenocortical function, to help meet the increased need for this vitamin during stress situations.

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Prednisone	0.75 mg.	Aluminum hydroxide	75 mg.
Acetylsalicylic acid	325 mg.	Ascorbic acid	20 mg.

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- to aid in promotion of growth and stimulation of appetite in poorly nourished children

Each teaspoonful (5 cc.) supplies:

Elemental Iron	38 mg.
(as ferric ammonium citrate and colloidal iron)	
(equivalent to 130 mg. ferrous sulfate exsiccated)	
Vitamin B_{12} activity concentrate	4 mcg.
Thiamine mononitrate	1.0 mg.
Riboflavin	1.0 mg.
Niacinamide	5 mg.
Pantothenic acid (Panthenol)	1.5 mg.
Pyridoxine hydrochloride	0.5 mg.

Alcohol content: 12 per cent

Dosage: 1 or 2 teaspoonfuls t.i.d.

Supply: Bottles of 8 ounces and 1 pint.

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Squibb Quality—
the Priceless Ingredient

"RUBRATON"® IS A SQUIBB TRADEMARK

Now...control both
the G.I. disorder
and
its
"emotional
overlay"

ANNOUNCING
PATHIBAMATE*

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SQUIBB IRON, B COMPLEX AND B_{12} VITAMINS ELIXIR

- to correct many common anemias
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Supply: Bottles of 8 ounces and 1 pint.

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Squibb Quality—
the Pediatric Ingredient

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Meprobamate with PATHILON® LEDERLE

for gastrointestinal tract disorders and their "emotional overlay"

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PATHIB

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Widely prescribed tranquilizer-muscle relaxant. Effectiveness in anxiety and tension states clinically demonstrated in millions of patients. Meprobamate acts only on the central nervous system. Does not increase gastric acid secretion. It has no known contraindications, can be used over long periods of time.[1,2,3]

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An anticholinergic noted for its extremely low toxicity and high effectiveness in the treatment of G.I. tract disorders. In a comparative evaluation of currently employed anticholinergic drugs, PATHILON ranked high in clinical results, with few side effects, minimal complications, and few recurrences.[4]

Now...with PATHIBAMATE*...you can control disorders of the digestive tract and the "emotional overlay" so often associated with their origin and perpetuation...without fear of barbiturate loginess, hangover or addiction. Among the conditions which have shown dramatic response to* PATHIBAMATE *therapy:*

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SPASTIC AND IRRITABLE COLON • ILEITIS • ESOPHAGEAL SPASM
ANXIETY NEUROSIS WITH G.I. SYMPTOMS • GASTRIC HYPERMOTILITY

AMATE

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• "I find it easy to keep patients using the drug continuously and faithfully. I feel sure this is due to the desirable effect of the tranquilizing drug."[5]

• "The results in several people who were previously on belladonna-phenobarbital preparations are particularly interesting. Several people volunteered that they felt a great deal better on the present medication and noted less of the loginess associated with barbiturate administration."[6]

• PATHIBAMATE . . . "will favorably influence a majority of subjects suffering from various forms of gastrointestinal neurosis in which spasmodic manifestations and nervous tension are major clinical symptoms."[7]

• "In the patients with functional disturbances of the colon with a high emotional overlay, this has been to date a most effective drug."[5]

'eferences: 1. Borrus, J. C.: *M. Clin. North America,* press, 1957. 2. Gillette, H. E.: *Internat. Rec. Med. & G. P. lin.* 169:453, 1956. 3. Pennington, V. M.: *J.A.M.A.,* press, 1957. 4. Cayer, D.: Prolonged Anticholinergic herapy of Duodenal Ulcer. Am. J. Dig. Dis. 1:301-309 uly) 1956. 5. McGlone, F. B.: Personal Communication to derle Laboratories. 6. Texter, E. C., Jr.: Personal ommunication to Lederle Laboratories. 7. Bauer, H. G. d McGavack, T. H.: Personal Communication Lederle Laboratories.

upplied: Bottles of 100 and 1000

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Naturally not. Missing calibration makes it worthless.

Equally useless and dangerous is a "quantitative" urine-sugar test that does not quantitate dependably, or omits readings in the critical range.

Enzyme urine-sugar tests are sensitive and specific for glucose—excellent "yes" or "no" tests but undependable for quantitation. King and Hainline,[1] after testing 1,000 urines, found an enzymatic urine-sugar test unable to distinguish in the important range between ½ per cent and 2 per cent or more of urinary glucose. Leonards,[2] in a report on 4,020 tests, revealed that "...in 502 out of 804 tests the wrong interpretation was made." He concluded that enzymatic urine-sugar testing "...as a quantitative procedure is unsatisfactory and can lead to serious error in the interpretation of a patient's clinical condition."[2]

Failure to recognize this limitation of enzyme tests may result in incorrect insulin dosage,[2] and may lead to diabetic complications.

(1) King, J. W., and Hainline, A., Jr.: Commercial Glucose Oxidase Preparations for the Detection of Glucose in Urine, Cleveland Clin. Quart. **23**:212, 1956. (2) Leonards, J. R.: Evaluation of Enzyme Tests for Urinary Glucose, J.A.M.A. **163**:260 (Jan. 26) 1957.

reliable readings throughout the critical range—
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a more serene, a happier pregnancy
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Cyclizine Hydrochloride and Pyridoxine Hydrochloride

because 'Maredox' gives the expectant mother new-found relief from morning sickness.

relieves nausea and vomiting
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Each tablet of 'Maredox' contains:
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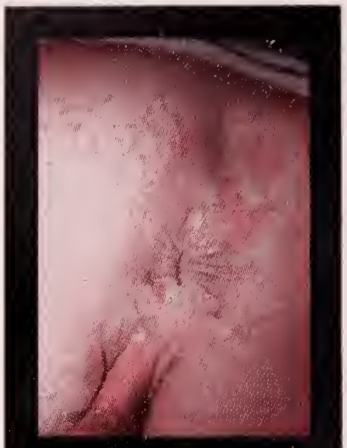

BEFORE
Reddened, fissured and excoriated perianal skin, and whitening of the anal folds, accompanied by intense burning and itching of 3 years' duration.

A new therapeutic approach with inherent safety in PRURITUS ANI

HYDROLAMINS®

TOPICAL AMINO ACID THERAPY

AFTER
Same case after treatment with Hydrolamins. Note healing of the inflamed, fissured and excoriated areas and of the whitened anal folds.

Unique physiologic barrier—topical amino acids—brings rapid relief (98%[1]) and complete healing (88%[1])

"...the objectives of therapy in pruritus ani can be listed under 3 headings:

(1) **relieve itching:** [Hydrolamins produced immediate relief of intractable itching in 98% of patients. The antipruritic effect of one application lasts about twenty-four hours.[1]]

(2) **accelerate healing,** [Hydrolamins rapidly and completely healed reddened, fissured, macerated and ridged perianal lesions in 88% of cases.[1]]

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SUPPLIED: In 1 oz. and 2.5 oz. tubes.

Lewal *Pharmaceutical Company*, *Chicago 14, Illinois*

1. Bodkin, L.G., and Ferguson, E.A., Jr.: Successful Ointment Therapy for Pruritus Ani, Am. J. Digest. Dis. 18:59 (Feb.) 1951.
2. Fromer, J.L.: Dermatologic Concepts and Management of Pruritus Ani, Am. J. Surg. 90:805 (Nov.) 1955.

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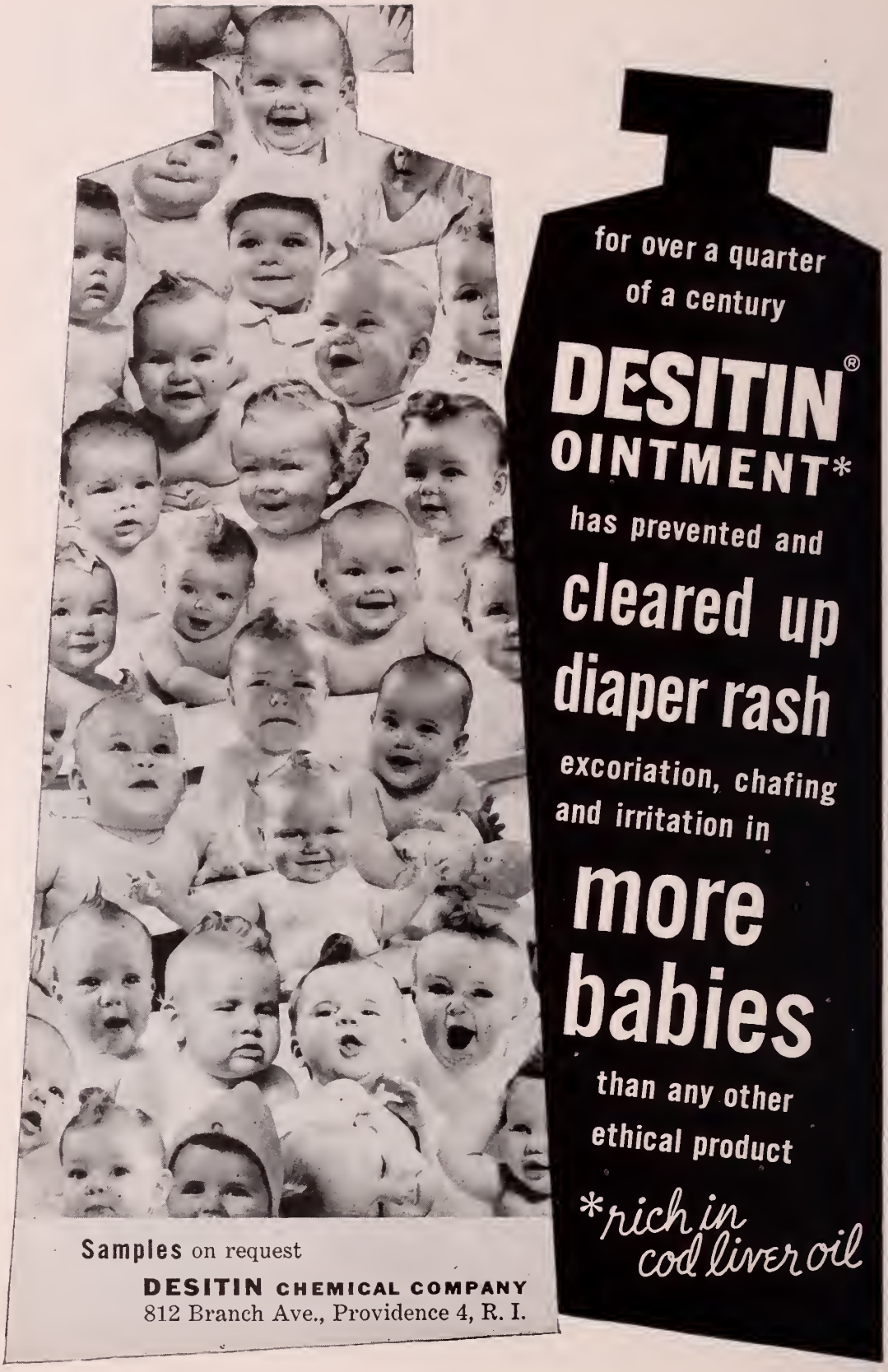
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The Doctor Goes to Court

Need for a New Order

RAYMOND R. KILLINGER, M.D.
JACKSONVILLE

Since Cain slew Abel, man has had his adversaries and from time immemorial has settled his difficulties with his adversaries in appropriate fashion with club, knife or similar instrument. Only in this modern age of socioeconomics has the settlement of difficulties been resolved into an argumentative procedure without resort to violence. Present court procedures, for example, are designed for the general welfare in order that justice may be done between man and man.

It is an inescapable fact that in the dynamic social, political and legal life of today legal problems arise which must be met and settled now in the light of the present day knowledge.[1] Their solution cannot wait decades for scientifically correct answers; otherwise, the Scopes trial would still be in progress. Unless court procedures are carried out expeditiously, business stoppages could well ensue that would eventuate in calamity.

Although physicians are no favored group in society, by virtue of their calling they are exempt from jury duty. For this exemption they should be profoundly thankful and should try to discharge in other ways their moral responsibility to society.

Most doctors at some time in their life probably will be called upon one or more times to testify in court. To do so is a moral and a patriotic duty of every physician. The doctor should accept this obligation as a part of life's pattern just as he does death and taxes.

At the outset, a basic statement is necessary.[2] It is not the duty or function of the medical expert to win a case, but rather to inform the court on technical matters in which he, the doctor, is especially trained. Not so the attorneys in a court clash of adversaries. They are employed to win. They are there to do or die in behalf of those they represent. Since the witness imparts information in response to questions, the attorney who asks them can win or lose the case on the strength of this testimony.

A doctor is at the call of the public, and not the least of his public duty is to help in the administration of justice by making available to the court his special knowledge of a case. If he is reluctant to appear willingly, the only alternative of the court is to issue a subpoena and pay a nominal witness fee.*[3] If subpoenaed, he is required to appear early on the day of trial, wait until the case, assigned to a particular judge, has progressed from the choosing of a jury to the taking of testimony and the time when the doctor's testimony is required. This procedure may take hours or days. If he offers his services promptly and affably, these consequences will be avoided. It may make him more sympathetic to remember that he himself may be a litigant at some future time, requiring the aid of other physicians as witnesses in court. That thought will make him fully aware of the importance of giving most graciously and sympathetically his testimony for the benefit of his patients. Also, his voluntary cooperation will foster a grateful relationship with members of the bar and respectful gratitude from his patients. To testify in court, then, is a privilege, which should be accepted with alacrity.

Doctor's Rights and Exemptions

In a court of equity and justice, no doctor should submit to badgering, bullying and unnecessarily rough treatment from an unscrupulous lawyer who can win his cases no other way. The physician always has a friend in the judge, whose duty is to stop persecution, and, if he thinks it necessary, he should call upon the judge to protect him from improper examination. Some unscrupulous lawyers may try to summons him on an

*In this state, a90.231 Florida Statutes allows " . . . ten dollars per hour or such amount as the trial judge may deem reasonable . . ." to be taxed as costs.

ordinary witness subpoena and get expert testimony. Under such circumstances, the doctor should give all the information asked for until he is called upon for an opinion. Then, if he has been qualified as an expert, he deserves an expert's fee. In such cases, he should appeal to the judge to excuse the jury, explain his point and then leave the matter to the judge, who will see that he is treated fairly.

Another matter physicians want to know about is exemptions, or, as lawyers say, whether information from his patient is privileged and may not be disclosed by the doctor even in court. So far, in a general way in Florida there are none, but in some other states the information is privileged. There are exemptions of a political nature as between heads of government, state secrets between governmental departments, professional secrets between attorney and client, and marital secrets between husband and wife. When an examination as a witness is for the purpose of securing relevant information obtained from the patient, and the treatment given, the information obtained may be disclosed on the stand. Consultants, as they may also treat in most states, must regard privilege. Findings at autopsy generally are not confidential. Information on commission of crime or unlawful acts is not privileged or protected.

The Complaint and Answer

How does litigation develop? From the days of the old English Common Law right up to the present, litigation has consisted in the main of a complaint by a plaintiff and the answer of the defendant filed thereto. The person filing the suit is called the plaintiff, and his lawyer files a complaint setting forth the charges of wrongdoing by the defendant and his request for compensation for those wrongs. To that complaint the defendant files, within a certain time, his answer. Generally, almost without exception, the defendant denies what the plaintiff sets forth in his complaint, thus creating the issues in the case. These are referred to as the triable issues of fact. To doctors, it may seem strange that preliminarily the court and jury have no function in selecting the issues to be tried. By the same token, physicians have no duty or responsibility to determine those issues, for that is the function of the jury. The members of the jury are the only ones who make that determination under the principles of law explained to them by the judge. The responsibility of the doctor is to state what he knows factually and truthfully in order to help the jury determine the issues. Obviously, in holding to the truth, he owes a responsibility not only to the patient, who is, generally, the plaintiff, but also to the court and to the community to provide the information peculiarly within his knowledge for assistance in reaching the truth. As the law says, "The verdict must speak the truth," for the construction of the word "verdict" stems from the use of the Latin word "veritas," meaning truth. The truth, the whole truth and nothing but the truth obviously means that the latter two qualifications refer to specific information about a specific thing or things.

The Subpoena

There are two types of subpoena: *Ad testificandum* merely requires oral testimony. *Duces tecum* requires that the doctor testify and bring with him the pertinent records. Regardless, it is best for him to bring his records in continuity and in original form with no supplemental data — in other words, just as they are without any doctoring because the cross-examiner usually will ask to see them and they may be made a part of the record.

Kinds of Witnesses

A material lay witness is one who testifies as to facts within his knowledge, and he can be made to answer "Yes" or "No" in many instances, but may explain his answer; usually, however, his opinion is not received. An expert witness testifies as to his technical opinion by virtue of his special training and can insist a proper qualification be added to his answer.

Preparation for Trial

Preparation for the witness stand begins long before the trial. Teamwork of the attorney and the expert is essential. The attorney gives the doctor facts and legal aspects. The doctor gives the attorney a general medical picture and follows up on specific information. After they have familiarized themselves with general and specific issues, the doctor is ready for questions and answers in four forms:[5]

1. Direct examination by the attorney on his team.
2. Hypothetical questions by the same attorney.
3. Cross-examination by the attorney on the opposing team.
4. Re-direct examination by the attorney on the same team.

All information from the expert, therefore, comes from questions and answers, and these should be worked out before the trial. At no time may an expert give information not germane to the questions. Life is full of what may be called rules of exclusion, rules that reject evidence even though it is both material and true. There is an exception to this court ruling in the "omnibus" type of questioning: "Doctor, tell the court and jury all you know about this case." This method of questioning is employed only by a lazy or incompetent team and should have no place in present day jurisprudence. The questions and answers should move along in simple language, be brief, and unfold developments like a plot in a story. The hypothetical questions should be the culmination of the testimony. They should summarize the facts in evidence to present fairly the views of the attorney favorable to his client. The premise includes facts in the case and interpretation by the team. When finally asked if he has an opinion, the expert calmly says that he has and states it in a few well chosen and well remembered words.

Probably ineptitude as an expert witness stems from three factors:

1. Most medical schools are too crowded for training in this realm.
2. There are no satisfactory postgraduate courses.
3. Few doctors consider the subject sufficiently important to devote time to it for study.

Obviously, it is impossible to be an expert in all fields of medicine;[5] yet the court and attorneys, by custom and law, expect the impossible. Ordinarily, a physician is careful as to medical allegations. Not so in the court room. There is something about the scene that makes the doctor throw caution to the wind. He becomes an expert in all things. The result is fantastic. For example, the law allows him to testify by a peculiar interpretation that reasons as follows: Insanity is a disease; hence, one who is skilled in detecting and treating disease is competent to give an opinion although in his practice he refers a patient with mental disease to a psychiatrist.

Most trials are before both judge and jury. The ideas expressed here are applicable whether the trial is before the judge alone in his chambers or before both the judge and the jury. They also apply to hearings before the trial, whether by deposition or otherwise. Deposition simply means sworn testimony before an authorized official, intended to be used as evidence in court without the appearance of the witness. Often this procedure is a quick way to settle differences of opinion in advance of trial, thus obviating costly court proceedings with all their implications to the taxpayer.

Much is said about the psychological atmosphere[2] in the court room being totally new and different, and so it is different from the office and hospital. The physician, however, is the same. He should be himself, dignified and confident, looking the judge and the jury in the eye. Many a young doctor fears the torture of a brain washing; yet he fails to remember all he had to go through to get his M.D. degree. All was not serene when he took graduating examinations and those of state boards or certification boards. He has had it rougher than anything to which the courts can subject him.

Once he knows all about what he will be asked in a general way and is thoroughly familiar with the case, the doctor who is at home in his own professional field is confronted by an opposing attorney who is technically out of his field. Nevertheless, let him not be deceived; the attorney has court room training and psychology to counterbalance his professed ignorance of medicine. In addition, he has studied every possible medical source of information on the case in question. If the doctor makes a point, he should stick to it. The witness, if he has written on medical subjects, should check these to be sure he is not now expressing a conflicting opinion on similar medical facts to those dealt with in the doctor's writings. An index to all published writings is available to the public in many libraries.

If the attorney whittles him down to "yes, but,"[2] doubt becomes apparent to the jurors, and it would be better if he had not gone to court.

Court Appearance

In practice, the doctor makes the decisions and gives the orders. In court, there is a difference of opinion or there would be no trial,[2] and the doctor's testimony is a basis for deciding the issue. The cross-examination is the best device invented to bring out the truth; therefore, the doctor will not have his statements go unquestioned. It is not one man's opinion as to what is the truth. Let him stick to facts, or what he knows, and be concise and to the point. He should guard against being technical[2] and of necessity

should use common terms. If he talks to the humblest person on the jury, the remainder of the court will follow. If he is not sure he understands the question, he should have the reporter read it to make certain that he fully comprehends.

It is important that he never lose himself. Remembering all he has said, if he now and then will quote verbatim some of his earlier remarks, he will win esteem in the minds of the jurors. Above all, he should never lose his temper, even when those about him are losing theirs. It is an old trick of the boxing ring to make the opponent mad and lower his guard. Also, another counter trick is to gain a little time to collect his wits by counting ten, asking the reporter to repeat the question and then starting anew.[2] Too much hesitation in answering, however, may unintentionally leave the impression of insincerity or lack of knowledge.

Certainly, it is not wise to argue with the lawyers, and especially with the judge.[1] It is also well to remember that the jurors like and respect the judge as he has already prepared them for the important task they have in finding the facts. They are the ones to be reached. The members of the jury are not patients to take without question the doctor's orders or words. They will be receptive, but will eye the doctor critically. He will do well to make them feel that they know far more than he does except for the one fact he wants to impress on them.

Compensation

Surely the workman is worthy of his hire. Usually those who appear as a medical expert often soon have an understanding with the counsel and base the fees for their work on the time involved, as they would in fixing compensation in their practice. The doctor makes so much per day based on federal income tax records. He uses so much time in looking up records, in consultations with attorneys, in consulting hospital records, and in doing a bit of reading or research; in addition, there is all of his time in court, and finally portal to portal pay. Depositions are proportionately the same and separate from actual court appearance. It is noteworthy that a 9023 Florida Statues permits a trial court to tax a reasonable fee for an expert witness whose deposition is taken.

If the patient is indigent, the bill is uncollectable. If the doctor refuses to testify, he will be served with a subpoena, which is a written order commanding the attendance of a person in court under a penalty for failure to obey. Usually, the process is issued by the adverse party, who expects his help; however, if no witness fee accompanies the subpoena, or has not been made available otherwise, he may refuse it. Always, when uncertain, he should apply to the judge, if necessary, in writing.

The best plan is to have all details regarding compensation worked out in the preliminary preparations for trial by either or both attorneys or the judge. As stated in the common law, the courts are courts of equity for the impartial administration of justice with due regard to the rights and claims of all. Also in the preliminary agreement, the doctor may arrange to be put "on call" and thereby save himself much time and inconvenience. In addition, if an unforseen emergency should arise in his practice, with the permission of the court he has the privilege of testifying out of order.

Expert Medical Testimony

In any litigation, it is the right of either side to bring in such supporting testimony as it properly can secure. At present, however, the court is often confronted with a direct conflict in medical testimony as introduced by the two sides. A suggested plan, now working in many places, is to provide as a source of expert medical testimony a broad panel of qualified experts subdivided into special fields in the state or county medical societies, to be revised yearly on the basis of past performance. These physicians should first have unquestioned integrity, be outstanding in their field, and have ability in the expression of technical knowledge and the specific implications to be drawn therefrom.

Recent editorial comment in the Journal of the American Medical Association on medical expert testimony is noteworthy:

"Today, justice is dependent to some extent on medical evidence in about half the cases brought to appellate courts in the United States. Every trial is an adversary procedure. One party wins, another loses. In theory, in all actions, it is the truth that is sought. It is obvious that neither court nor jury is in a position, unaided, to resolve medical problems, to evaluate, intelligently, causal relationships or effects. The medical expert witness has the opportunity and the privilege to aid the court and jury in arriving at the truth. It is his function to assist in the administration of justice.

New York Academy of Medicine and the New York County Medical Society designating the medical talent, and has been "adopted as a regular part of the operations of the Supreme Court of the State of New York in the First Department." The basic idea of the Project revolves around panels of "neutral outstanding physicians in various specialized branches of medicine." Available at the call of the court, these experts make medical examinations of plaintiffs in personal injury cases, report their findings, and, if necessary, testify in those cases in which medical aspects are controversial and substantial. These unquestionably expert members of the medical profession, Dr. Alvarez noted, do not have to depend for their remuneration on either the prosecution or the defense. Their fees are charged against Project funds. Such panels, he observed, make trials much more dignified with less hysteria and more good sense. In addition, trials have thereby been shortened, a result that is particularly gratifying since approximately 80 per cent of the cases in trial courts of the country are personal injury cases, involving the taking of medical testimony, and courts are often years behind in their work.

Need for a New Order

On May 22, 1956, Dr. Walter C. Alvarez,[7] through his syndicated column "How to Live," made astute observations on "The Need for Impartial Medical Expert Testimony." He declared that for 45 years he had seen the need for a new order and warmly endorsed "Impartial Medical Testimony,"[8] a book just published by The Macmillan Company. This book is recommended reading for every physician, lawyer and jurist in America. The New York Medical Expert Testimony Project described in the book has been in operation since 1952 in New York City, with the

"Opinion evidence, as a whole, is not looked on with great favor by the law. It is probable that juries are more prone to distrust the testimony of the medical expert witness than the testimony of any other witness. Laymen find it difficult to understand how honest physicians may express contradictory opinions. Jurors do not at times seem to attach any higher credibility to the testimony of physicians of high standing than to that given by the 'professional' expert witness. . . .

"Although medicine is not an exact science and although it is the opinion of the expert witness that is generally of primary importance, it is believed that in most instances a panel of impartial medical experts would be able to find basic agreement and that their conclusions would reflect the truth that the court and the jury seek."[6]

Appointment by the court of medical experts, whose services are paid for usually by the defense in the first instance, is still another way to secure unbiased expert medical advice. This method is now widely used.

As the title of the book indicates, the new order seeks the antithesis of partisan medical testimony as now too frequently practiced by a considerable group of lawyers and doctors who do not conform to the highest traditions of their calling. An impartial expert gives confidence to judge and jury in understanding the technical aspects of a problem. Although the legal and medical professions have made efforts to curb abuses in the presentation of medical proof, "this Project represents the first major effort in the personal injury field to cope with the problem by arming the judge with facilities as well as power to appoint neutral, competent medical experts."

Interestingly enough, Professor Delmar Karlen of the Institute of Judicial Administration of the New York University Law Center, as research director, and Dr. Irving S. Wright, Professor of Clinical Medicine at the Cornell Medical College, as medical consultant for the Project, reached substantially the same conclusions, the one from the legal and the other from the medical viewpoint, in their independently written reports. They and the other members of the Committee on the Medical Expert Testimony Project, reporting after a highly successful two year trial of this pilot project, cited the following accomplishments:

"1. The Project has improved the process of finding medical facts in litigated cases.

"2. It has helped to relieve court congestion.

"3. It has had a wholesome prophylactic effect upon the formulation and presentation of medical testimony in court.

"4. It has proved that the modest expenditure involved effects a large saving and economy in court operations.

"5. It has pointed the way to better diagnosis in the field of traumatic medicine. Unlike the others listed above, this accomplishment is an unexpected dividend, which was not in contemplation when the Project was initiated."

Conclusions

The great majority of cases in trial courts are personal injury cases, requiring the taking of medical testimony.

The average doctor is inadequately prepared for and dislikes to appear in court.

The time is propitious for both the medical and the legal professions to clear themselves of any suspicion of bias and prejudice in the mind of the public and to renew efforts to secure only the truth.

To obtain unbiased nonprejudicial medical expert testimony in personal injury cases, a system based on the New York Medical Expert Testimony Project described in "Impartial Medical Testimony" is recommended.

Such medicolegal collaboration offers the best remedy yet proposed for the deficiencies and abuses prevailing in the presentation of medical proof in judicial proceedings by enlisting the services of independent and impartial medical experts to aid the court in the better and quicker disposition of those cases which are most voluminous in the courts of this country.

An outstanding example of successful interprofessional cooperation, the Project charts the way toward a new order which offers a solution to the universal problem of securing better medical testimony, not alone in personal injury cases but also in other types of litigation in which the physical or mental condition of a litigant may be involved. This approach improves the administration of justice, upholds the best traditions of the medical and the legal professions and promotes favorable public relations.

Appreciation is expressed to the many members of The Jacksonville Bar Association who gave helpful guidance in the preparation of this paper.

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225 West Ashley Street.

Determining Immunity Level in a County

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In November and December of 1955, there was a mild epidemic of diphtheria in DeSoto County. In a total of 12 cases, all of the patients were white, and fortunately, all but one recovered without any apparent sequelae; in the one case the disease was fulminating in type, and the patient died. Because of the public alarm at that time, the staff of the DeSoto County Health Center gave a markedly increased number of immunizations for the months of November and December. In November, we gave 288 diphtheria inoculations, 143 being given to children five years of age or older. In December, we gave 370 diphtheria inoculations, 329 being given to children five years of age or older. During these two months only eight smallpox vaccinations were given. For the entire year of 1955, there were 863 diphtheria inoculations given in the DeSoto County Health Center, and 658, or 76 per cent, of these were given during November and December. Needless to say, as soon as the public lost its fear, the rate of inoculations immediately dropped drastically; in January 1956 there were 88 and in February only 28. These figures are from the records of the Health Department only and include no inoculations given by the practicing physicians of this county. They fairly well reflect the immunity in the community, however, as we give about two thirds of the inoculations in the county.

Because of this epidemic and the resultant mass inoculations, Dr. L. L. Parks, Director of the Bureau of Special Health Services, thought that it might be interesting to attempt to determine the immunity level in the county. It is true that "fools walk in where angels fear to tread," as I aptly demonstrated by deciding to make a survey in all three of my counties, comprising the DeSoto-Hardee-Charlotte Health Unit, rather than in just one county. Had I realized the amount of work involved, I assuredly would not have

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Read before the Florida Health Officers' Society, Eleventh Annual Meeting, Miami Beach, May 13, 1956.

done it; but I had a bull by the tail and could not let it go, and so I completed the survey.

Dr. Parks kindly offered me the services of Dr. James O. Bond, Epidemiologist of the Florida State Board of Health, in conducting this survey, and I accepted his help gladly. Dr. Paul W. Hughes, Director of the Broward County Health Department, was unknowingly a big help to me as I used his survey forms, somewhat modified at the suggestion of Dr. Parks. All of the schools cooperated willingly in passing out and collecting the survey sheets. The clerks and nurses in my counties helped, and my wife prepared the graphs. To all, I give my sincere thanks for their help.

In this survey I chose two groups in attempting to determine the immunity level. I sent survey forms to all families with a child who was one year old in January, February, March and April of 1956, and I sent survey forms to all pupils in the public schools from the first through the twelfth grades, both white and Negro. In tabulating the school children, they were separated into white and Negro, and then the results were combined to give a community level. I know that these statistics are open to possible error as we did not get 100 per cent cooperation from the families, but I do believe they accurately indicate the county immunity level. Inasmuch as the high schools were included, I believe the figures would indicate the adult immunity level in these counties as well, since those who are beyond school age are less apt to be adequately immunized than are those who are younger.

Results of Survey

I will attempt to discuss and compare the findings of all three counties by diseases. The returns by percentages, however, are presented first. The one year olds were not separated by race and the returns were: Hardee County, 43 per cent; DeSoto County, 28 per cent; and Charlotte County, 67 per cent. The school children were divided according to their grades, and the total returns for all the schools in each county were: Hardee, 83 per cent; DeSoto, 68 per cent; and Charlotte, 65 per cent. In Hardee County, the participation was excellent in both white and Negro children through the sixth grade, but from there on the returns for white children were especially poor. In DeSoto County, the Negro pupils ceased to be cooperative at the fifth grade, but cooperated well in the tenth and twelfth grades; cooperation of the white pupils fell off rapidly after the ninth grade. In Charlotte County the returns for Negro pupils were greatest, but extended only to the sixth grade; the returns for the white pupils were good in only the first three grades and again in the eleventh and twelfth grades.

The findings now presented are on smallpox vaccinations and revaccinations. In determining immunity in this instance, a level of 70 per cent vaccinations or above was considered excellent, but a revaccination within five years would also have to be given. Those who recorded that the vaccination "did not take" were listed as not having any protection. It was assumed that after five years, immunity would be greatly reduced unless a revaccination was given. With these thoughts in mind we found that of the Hardee County one year olds, only 18 per cent were vaccinated; in DeSoto County, only 13 per cent; and in Charlotte County, 60 per cent. In all the counties, therefore, the immunity level was dangerously low in this age group, except for Charlotte which was 10 per cent too low. In the other age groups in Hardee County, the original vaccination level was above the 70 per cent rate, but only in the sixth grade of the Negro schools was the revaccination level up to 70 per cent; in all other classes, for both white and Negro pupils, the level was below 45 per cent, which is totally inadequate for protection. In DeSoto County, the original vaccination rate was 70 per cent or above only in the first, second and sixth grades for Negroes and in the second and seventh through the twelfth grades for white pupils. The revaccination rate fell off rapidly from the second grades for white pupils and was never at anything approaching a safe level. In Charlotte County, the original vaccination rate was adequate in the second through the eighth and in the tenth through the twelfth grades; in the Negro schools, it was adequate in the first through the third and in the fifth and sixth grades. The revaccination rate was especially poor in the white school, the highest being 55 per cent in the first grade and 50 per cent in the seventh grade; the revaccination rate for Negroes was a little better, being adequate in the first, second, third, fifth, and sixth grades, but the fourth grade had only a 65 per cent rate. So it can be seen that none of these three counties was adequately protected against smallpox.

The next to be examined is the diphtheria, pertussis and tetanus immunity. Again, a booster shot had to be given within the last five years before immunity could be assumed. In Hardee

County, the original level for diphtheria was well above 70 per cent in all grades of the white schools and in all but the seventh grade of the Negro school. In none of the grades of the schools, for white or black, however, was the number of booster shots over 55 per cent, in most instances being well below 40 per cent. In DeSoto County, the original level was satisfactory in all the white schools and poor in the Negro schools with the exception of the first, second, third and twelfth grades. The level of the booster shot was up to 70 per cent in the second grade only of the white school; in all other classes for both white and black, it was most inadequate. Think how low it must have been before we gave the 658 "shots" last year during the epidemic. In Charlotte County, the number of original inoculations was above 70 per cent in all classes for white pupils except the first and ninth; in those for Negroes it was adequate in all but the third and fourth grades. On booster shots, the Negroes had a safe level in the second, fifth and sixth grades only; the white schools had a particularly poor level on booster shots, well below 70 per cent throughout. None of these counties, therefore, was adequately protected against diphtheria, pertussis or tetanus. An epidemic of diphtheria could readily occur in any one of these counties at any time. In case of hurricane, fire or other disaster, the level of protection for tetanus is much too low, and tetanus antitoxin would have to be given to the vast majority of the people.

The next item studied was the Salk poliomyelitis vaccine. In Hardee County, the level was above 70 per cent in only the second and third grades, corresponding to the grades in which the pupils were given the vaccine in the schools last year. From there on it dropped below 40 per cent in all schools. In DeSoto County, in the second and third grades in the white schools it was above 75 per cent, but below 35 per cent thereafter. In the second grade in the Negro school it was 57 per cent and in all the remainder much lower. In Charlotte County, it was 75 per cent in the second and third grades of the white school and 80 per cent in the second grade of the Negro school. From there on, in all it was well below 50 per cent. We are continuing, however, to give a sizeable number of Salk inoculations every week in all three counties so that these figures do not truly depict the level except on the date the survey was completed, March 9, 1956.

Dr. Parks thought it might be interesting to determine what percentage of vaccinations and inoculations was given in the health departments and in private physicians' offices. I was surprised to find that the majority of the immunizations were being given in the Health Department for both the white and Negro race. In Hardee County, over 70 per cent of all immunizations for Negroes were given in the Health Department and over 50 per cent of all inoculations for white persons were also given in the Health Department. In DeSoto County, over 50 per cent of the immunizations for both races were given in the Health Department. In Charlotte County, again, over 50 per cent of the immunizations were given in the Health Department.

Conclusion

As I stated in the beginning, these statistics are open to a great degree of error, but this study nevertheless has impressed upon me the complacency of the public in regard to its health. Health is an intangible possession, and good health is taken for granted; it is never valued until it is lost. This survey has shown that the immunity levels in the three counties studied for smallpox, diphtheria, pertussis, tetanus and polio are dangerously low, and every effort will be made to raise them in the future.

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Diamox in Edema of Pregnancy

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Acetazoleamide (Diamox, Lederle) is a sulfonamide which was originally introduced as an oral diuretic for the management of patients with congestive heart failure. The manufacturers now advertise it also as being useful in epilepsy (petit mal) and acute glaucoma.

Its action as an inhibitor of carbonic anhydrase in the distal tubules of the kidney enables it to initiate and maintain excretion of base by interfering with the phosphate buffer system or the transfer of base across the tubular barrier. This excretion of base is accompanied by an obligatory excretion of water.

Shortly after the introduction of this drug, we were prompted to attempt its use in the treatment of patients with sodium retention and edema of pregnancy. Our first patient was carefully searched for and received a tremendous therapeutic success, losing 13.25 pounds or 4.5 per cent of the total body weight over a period of 48 hours. This result was accomplished simply by administration of 500 mg. of Diamox daily and restriction of sodium in the diet, the weight being recorded before and 48 hours after the beginning of the administration of Diamox.

Thereafter, for a period of nine months we utilized Diamox in our obstetric practice, which is about 30 per cent of a combined general practice. We delivered a total of 323 patients in that time. Of this number 285 were given no Diamox. Thirty-eight patients were given Diamox with the following results: Seventeen patients received no help. Three patients stopped taking it because of numbness and tingling of the extremities, lips, and tongue. Eighteen patients received what they thought was help (table 1). The records of these 18 patients were then catalogued and the results studied (table 2). All 18 were given maintenance doses of Diamox, and the potentially toxic or preeclamptic state was controlled. Thirteen were greatly relieved of edema, five completely. Three stopped losing albumin in the urine, and one received remarkable relief from the hypertensive state (40 mm. Hg. systolic drop).

In studying the data on these patients, one curious fact was noted. Those patients weighed 48 hours after the beginning of administration of Diamox experienced maximal measurable loss in weight, whether measured in pounds lost or percentage of total body weight.

With this observation in mind, a controlled series of 20 consecutive toxic patients was studied in the following manner: When Diamox was deemed necessary, the patient was weighed and given three Diamox tablets. She was instructed to take one tablet immediately, one the next morning and one the following morning. While taking Diamox she was further instructed to eat no salty foods and to add no salt to food already cooked, but she was allowed to eat ordinary food with its normal sodium content. She returned in 48 hours and was weighed again. The results are recorded in table 3.

This series of patients was controlled with a similar series of 20 consecutive patients who fulfilled the following criteria: They all were within the tenth lunar month of pregnancy; they exhibited less than 25 pounds gain in weight; there was no edema, hypertension or albuminuria. These were given Diamox, and sodium was restricted in a manner identical with that used in treating the so-called toxic patients; they were weighed again in 48 hours. The results are recorded in table 4.

These figures were compared and subjected to statistical analysis.[1] They are highly significant, with similar results being reproducible by chance less than one time in 350 (t equals 3.06; p approximates 0.004).

Table 1.—Summary of 323 Obstetric Patients

Normal Pregnancy No Diamox	285	
Complicated Pregnancy Diamox	38	
No benefit		17
Benefit		18
Stopped (tingling)		3
	323	

Table 2.—Experience With Diamox in Edema of Pregnancy

Patient	Month of Pregnancy	Weight Before Diamox in Pounds	Weight After Diamox in Pounds	Interval In Days	Weight Loss	Per Cent of Weight Loss
1	8	290.25	277.00	2	13.25	4.5
2	8	175.25	170.00	2	5.50	3.1
3	8	169.00	165.75	7	3.25	1.9
4	8	128.25	126.00	14	2.25	1.7
5	8	195.00	189.50	3	5.50	2.8
6	8	195.00	193.50	10	1.50	0.8
7	7	131.50	130.75	30	0.75	0.6
8	8	126.00	123.50	7	3.50	1.9
9	8	190.50	187.00	7	2.50	1.3
10	8	132.50	131.50	7	1.00	0.8
11	8	145.00	144.00	7	1.00	0.7
12	7	135.00	131.00	8	4.00	3.0
13	8	160.00	151.00	2	9.00	5.9
14	8	255.00	254.00	7	1.00	0.5
15	9	165.00	162.00	14	3.00	1.8
16	8	155.50	153.00	14	1.50	1.0
17	8	135.00	131.00	2	4.00	2.9
18	8	122.00	121.00	14	1.00	0.8

Table 3.—Toxic Patients in Forty-Eight Hour Diamox Test

Patient	Month of Pregnancy	Indication	Weight Before Diamox in Pounds	Weight After 48 Hours Diamox in Pounds	Weight Loss in Pounds	Per Cent Body Weight Loss
1	5	12 lbs. weight gain	160.75	152.75	8.00	5.0
2	7	10 lbs. weight gain	161.50	159.50	2.00	1.2
3	6	8 lbs. weight gain	140.00	138.00	2.00	1.4
4	7	Feels swelled	155.00	152.00	3.00	1.9
5	7	Edema	152.00	150.00	2.00	1.3
6	7	14 lbs. weight gain	136.75	133.50	3.25	2.4
7	9	Edema	150.50	147.00	3.50	2.0
8	9	Edema	156.25	148.75	7.50	4.8
9	9	Edema	160.75	157.25	3.50	2.2
10	7	Edema	161.75	159.50	2.25	1.4
11	6	9 lbs. weight gain	135.00	133.25	1.75	1.3
12	9	Edema	121.75	120.00	1.75	1.5
13	9	Edema	174.00	167.75	6.25	3.6
14	9	Edema	172.75	166.75	6.00	3.5
15	9	8 lbs. weight gain	130.00	126.75	3.75	3.5
16	7	12 lbs. weight gain	186.75	182.25	4.50	2.4
17	8	Edema	201.25	199.50	1.75	0.9
18	5	Edema	131.50	126.00	5.50	4.2
19	5	Edema	178.00	167.00	11.00	6.0
20	9	Edema	162.00	154.50	7:50	4.9

Table 4.—Control Patients in 48 Hour Diamox Test

Patient	Weight Before Diamox in Pounds	Weight After Diamox in Pounds	Loss in Pounds	Per Cent of Weight Loss
1	132.25	130.50	1.75	1.3
2	170.00	163.00	7.00	4.1
3	132.50	132.25	0.25	0.2
4	132.25	131.00	1.25	1.0
5	176.25	170.00	6.25	3.8
6	137.75	135.50	2.25	1.6
7	126.00	126.00	0.00	0.0
8	138.25	133.00	5.25	3.8
9	148.00	147.00	1.00	0.6
10	129.00	129.00	0.00	0.0
11	146.00	143.00	3.00	2.0
12	126.00	125.00	1.00	0.8
13	180.00	178.00	2.00	1.1
14	113.00	112.00	1.00	0.9
15	138.00	134.00	4.00	2.9
16	115.00	115.00	0.00	0.0
17	132.00	132.00	0.00	0.0
18	111.00	108.00	3.00	2.7
19	144.00	141.00	3.00	2.1
20	126.00	125.00	1.00	0.8

The only toxicity reported was a reversible numbness and tingling of the tongue and extremities. No effect of permanent nature was observed in either the mothers or the babies. Two patients subjected to the 48 hour Diamox test gained weight since this series was completed.

Summary and Conclusions

There is an increased reabsorption of sodium and water in the pregnant woman, especially in the tenth lunar month.[2] This normal process is exaggerated in the pre-eclampic or toxic state, and is at least part of the cause of eclampsia. Control of sodium and water excretion is therefore partly the answer to the control of eclampsia.

Diamox is a potent drug to increase sodium excretion in those patients who are potentially toxic. That this increased excretion is significant is demonstrated by the controlled series reported.

A convenient way to evaluate the sodium retention of the potentially toxic gravid patient is described as a 48 hour Diamox test. The patient is instructed to restrict sodium intake; then she is weighed, given Diamox on three consecutive mornings and weighed again after 48 hours. A loss in weight of 2 per cent of the total body weight is indication that further Diamox therapy is justified.

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Thalassemia Minor

Experience With Fifty Consecutive Patients

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NEW ORLEANS

Thalassemia minor, also called target cell anemia, Mediterranean anemia and familial microcytic anemia, was first described in the American literature and shown to be a part of the Mediterranean syndrome in 1940.[1-3] Fifteen years earlier Cooley[4,5] described the major form of the disease, which is also known as Cooley's anemia, Mediterranean anemia and erythroblastic anemia. Prior to Cooley's description the major form was considered part of the ill-defined group termed von Jaksch's anemia, but since then it has become a well recognized entity.

In spite of a number of excellent publications discussing thalassemia minor,[6-12] there is still considerable confusion regarding its diagnosis and treatment. It is the purpose of this paper again to draw attention to this disorder by presenting experience with 50 consecutive patients with this disease referred to the Section on Hematology at the Ochsner Clinic.

Heredity

Thalassemia minor and thalassemia major have a relationship which in some respects resembles that of sickle cell trait to sickle cell anemia. In both, there is an inherited abnormality of the red blood cells, which results in severe anemia in the homozygous form, but in the heterozygous form is usually asymptomatic. There is this distinction between the two conditions: sickle cell trait does not cause anemia whereas thalassemia minor may.

Thalassemia is encountered chiefly in persons of Grecian, Italian, Spanish and Syrian descent. It has been reported several times, however, in the Chinese and also in the Negro, English, French, Filipino, Hindu and American Indian. The actual incidence of the disease among the American people will vary in different areas according to the racial descent of the population. In areas where a large proportion of the population is Italian, Greek, Spanish or Syrian, the incidence will be much higher. In America the intermixture of racial groups is so widespread that the trait is not infrequently seen in patients whose Mediterranean ancestry is one, two or more generations removed. Among the 50 patients in the present series were nine of Anglo-Saxon descent, three of French descent, and one whose only known Mediterranean ancestor, a Spaniard, was a great-grandparent. Thirty were of Italian ancestry, four of Spanish descent and four of Greek descent.

No attempt has been made to estimate the incidence of the disease in the southern area. Although most patients in the present series were from the Southern states, some were from other portions of the United States, and a few were from Central America. Thalassemia, however, is not a rare condition in the South, and a number of cases have been encountered in New Orleans in studying relatives of the patients in the present series.

Clinical Characteristics

Most patients with thalassemia minor have no symptoms attributable to it. Those with the lowest hemoglobin values may complain of mild fatigue, but it is difficult to correlate the two. Occasionally, the enlarged spleen may cause mild discomfort in the left upper abdominal quadrant.

Each person with thalassemia minor maintains nearly the same hemoglobin value throughout his adult life, unless he has an additional illness which also produces anemia. Among our patients it is noteworthy that those who had symptoms which had been attributed to anemia frequently had experienced these symptoms first on reaching some period of emotional stress well after maturity. In many instances the symptoms first developed after anemia had been recognized and the patient had undergone a prolonged period of futile treatment. There were no positive physical findings other than a variable degree of pallor and in 13 of 50 patients, a palpable spleen.

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Blood Changes and Other Laboratory Findings

Most patients with thalassemia minor have mild to moderate anemia. In a statistical study of 82 cases Valentine and Neel[13,14] noted a hemoglobin deficiency of only 2 to 3 Gm. and a red blood cell count usually over 5,000,000 per cubic millimeter. Anisocytosis and poikilocytosis are often prominent. "Target cells" are numerous. Erythoblasts or normoblasts are not present. Stippling is sometimes prominent. Oval or greatly elongated cells are frequently seen. In some instances the cells may have an increased diameter with a decreased thickness, appearing on the film to be large, hypochromic cells. Characteristically, the mean corpuscular volume (MCV) is low, the mean corpuscular hemoglobin (MCH) decreased and the mean corpuscular hemoglobin concentration (MCHC) normal or slightly below. There is increased resistance to hypotonic saline. Reticulocytes are normal or moderately increased. Indirect bilirubin is normal or moderately increased. The bone marrow has an increase in normoblasts. Serum iron is elevated, and the iron-binding protein is saturated.[15] Of great diagnostic significance are similar hematologic findings in one of the parents.

Electrophoretic studies have not shown abnormal hemoglobin in thalassemia. The recently described conditions with somewhat similar blood pictures, hemoglobin C and hemoglobin E diseases, may be differentiated from thalassemia minor by this method.

In the 50 patients whom we studied, only 10 had a hemoglobin level of less than 9.5 Gm. Of these, two had other conditions contributing to the anemia. In most instances the hemoglobin ranged from 10 to 13.5 Gm. The red blood cell count ranged from 3,200,000 per cubic millimeter to 7,000,000 per cubic millimeter. Several had a count below 4,000,000, though about one half had a count above 5,000,000 (table 1). In 19 cases reticulocytes were elevated above 2 per cent, the highest count being 7 per cent. Bilirubin was elevated in only two of the 10 patients in whom it was determined. The degree of anisocytosis, poikilocytosis and microcytosis was variable and did not correlate well with the level of hemoglobin.

Table 1.—Blood Values in Fifty Patients with Thalassemia Minor

Hemoglobin in Grams	Cases
7	1
7-8	2
8-9.5	8
9.5-11	24
11-13	11
13-15	4
Red Blood Cells in Millions	**Cases**
3-4	5
4-4.5	8
4.5-5	13
5-5.5	11
5.5-6	8
6-7	5

Diagnosis

Thalassemia minor must be differentiated from anemia due to chronic blood loss, hemoglobin C disease, chronic infection, and inadequate iron intake in the growing child. Ordinarily there is no difficulty in differentiating it from thalassemia major, since in the latter the anemia is more severe, nucleated red blood cells are present in the peripheral blood, and the symptoms of anemia are pronounced.

Hemoglobin C disease and hemoglobin C–hemoglobin S disease can be differentiated by electrophoretic studies. In like manner thalassemia–sickle cell disease can be identified. This condition, resulting from the combination of the thalassemia and the sickle cell genes, is a microcytic anemia, and the blood smear resembles thalassemia minor. It is a symptomatic hemolytic anemia, however, in many respects resembling sickle cell anemia. The sickling preparation is positive, and in the electrophoretic studies the S hemoglobin shows characteristic migration. The subject of abnormal hemoglobins is well covered by a recent review of Chernoff.[16] Microcytic anemia resulting from chronic infection can be diagnosed because the infection can usually be recognized. In anemia due to inadequate iron intake in the growing child a dietary history will usually give a clue to the diagnosis. Response to iron therapy restores the blood picture to normal and confirms the diagnosis.

Thalassemia minor is most likely to be confused with the anemia of chronic blood loss. In the latter the serum iron is lower, and the iron is decreased in the marrow. Anemia of blood loss responds rapidly to iron therapy, provided continued blood loss is not too severe. In anemia of chronic blood loss serum bilirubin is low. A helpful office procedure is to examine the plasma in the Wintrobe tube after one has determined the hematocrit reading. In the anemia of chronic blood loss the plasma is usually almost colorless whereas in thalassemia there is a faint icterus.

Conversely, the serum iron in thalassemia minor is not decreased. Iron in the marrow is increased. Bilirubin may be slightly elevated. There is no response to iron therapy. Most of the patients will be of Mediterranean ancestry. Study of the blood of siblings and parents is of great help. One will ordinarily find a similar condition in one of the parents and may find it in some of the siblings. The most helpful single procedure is careful examination of the peripheral blood smear. The anisocytosis, poikilocytosis, hypochromia, stippling, and target cells are seen in few other conditions in which the anemia is of such mild to moderate degree.

One should consider thalassemia minor in every patient of Mediterranean ancestry who has microcytosis with or without anemia. It is, however, well to remember that anemia of chronic blood loss is as frequent among these races as among others. It is also possible for further anemia due to blood loss or other conditions to develop in patients with thalassemia. In such cases there will be some improvement with correction of the blood loss and institution of iron therapy.

The diagnosis of thalassemia minor is easily established once it is considered. Before admission to the Clinic, anemia had been previously recognized in 39 of our 50 patients although the diagnosis of thalassemia minor had been considered in only four.

Treatment

There is no known effective medication in the treatment of thalassemia minor. Transfusion will, of course, raise the hemoglobin, but it is not indicated except perhaps in periods of stress, since the repeated transfusions necessary to maintain an elevated hemoglobin are hazardous, expensive and will lead to transfusion hemosiderosis. Cobalt is apparently ineffective and inadvisable despite some favorable reports.[17] Of greatest value in caring for these patients is reassurance. They should be told that the condition is not progressive, that it has been present since birth, that it ordinarily produces no symptoms, and that one of the parents had the same disorder.

Many of these patients have been treated for a number of years with iron, vitamins, cobalt and liver with or without other indications. A number are psychologically dependent on these medications. It is often futile to attempt to convince them that medication is of no benefit. Although such treatment is not physically harmful, with the possible exception of excessive iron or cobalt, those who have been treated the most energetically usually have the most severe functional complaints. Moreover, it is expensive, unnecessary and completely ineffective. One of our patients had been under treatment intermittently for 40 years. Thirty-four of the patients had been under treatment for periods up to 10 years.

Summary

Thalassemia minor is frequently overlooked as a cause of microcytic anemia. It is not infrequent among the Mediterranean races, is seen occasionally in patients of other racial extraction, and it not a rare disorder in the southern part of the United States. The diagnosis is not difficult to make once the condition is considered. Ordinarily the anemia causes no symptoms or only mild complaints. Among the patients we have seen, however, unrelated functional complaints are common, and fixation on the anemia due to prolonged and ineffectual therapy is often present.

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The Physician's Relationship With Other Members of the Team

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The increasing complexity of Medicine is such that no longer can the physician function as a solitary individual in whose hands lies all of diagnosis and therapy. The general practitioner and the specialist rely upon the skilled practices of laboratory technicians at work with complicated apparatus and detailed physiologic and biochemical technics and upon the skills of other specialists who may be working in close juxtaposition with him. In hospitals the physician works in a professional group which includes nurses, nursing aides, dietitians, occupational therapists, social workers, pharmacists and others. Once not long ago, he had professional training so much more thorough than these paramedical workers that they functioned entirely as technical assistants to him. Now almost all of the allied disciplines have developed their own fields to such an extent that the more rigorous intellectual and clinical training of their members places highly skilled and knowledgeable persons at his side as associates.

The community and the laity have demanded a share in working out their health salvation, and as a result, health and social agencies, voluntary lay health associations, and the community at large have become fellow workers in a common task. It has become increasingly less feasible for the physician to withhold much of what he does from a reasonable amount of public inspection. The average citizen has become a lay biostatistician and medical economist, and armed with figures on the incidence of chronic disease and on the cost of medical care, he now expects that he has the right to inquire into his physician's ideas and responsibilities on these subjects.

When medicine is practiced with more of a focus on the health of the population at large rather than on the individual, as in public health, the enormity of such practice demands an obvious division of labor between the public health officer, nurse, sanitarian, statistician, epidemiologist, and others. The nature of public health is such that its work lies closely enmeshed within the community, so that on the one hand it collaborates with a variety of professional disciplines, such as the local medical society, the Department of Public Welfare, and the school system, while on the other hand it works close to the vitals of the laity in the home, in the family, and in the neighborhood. To the public health officer, therefore, his relationship with others is a factor of which he is particularly conscious.

It is for that reason that I have been invited to discuss the physician's relationship with other members of the team. This is an intricate subject which lies beyond an inspirational clarion call to duty and responsibility for the physician, but because it is intricate does not mean that this particular aspect of relationship cannot be operationally effective. Relationship in this context means interaction between members of a group at work on a common task. Much knowledge on this specific type of interaction has come from the social sciences, psychiatry, and indeed from public health itself. Much of the investigative work on this problem has been done in the public health clinic and in the general hospital. An excellent approach to the subject from the standpoint of the public health officers' leadership and authority has been made by Szurek in a chapter of Ginsberg's book "Public Health Is People."

Much of what I want to present today demonstrates principles and conclusions from our own work on the functions of the clinical group carried out since 1947 at the Schools of Medicine of Duke University and the University of Maryland in conjunction with the State Boards of Health of North Carolina and Maryland, and which is being continued at the University of Miami School of Medicine. This work has consisted of numerous studies of the clinical team functioning on medical wards and outpatient clinics of general hospitals and in studies on the interrelationship of professionals in county Departments of Public Health. Particularly intensive study extending over a three year period was carried out at the University of Maryland on an experimental ward designed for

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the purpose of investigating the roles and functions of disciplines at work on health problems. This latter study will be cited from time to time in the course of this paper.

I should like to call particular attention to the threat to the leadership of the physician by the more recent concepts of team function. This threat poses the most singular problem to the individual physician, whether he be a general practitioner, specialist, academician, or public health officer. The specific problem at hand in this regard is that although the physician is viewed as the unquestionable leader of the clinical team, the changing order of medicine in all its modern complexity has given his leadership a different role from that which he has in times past envisioned. This topic I should like to discuss under certain headings, which comprise the body of the science of the small group, numbering two to 20, which is the usual design for the clinical team. These headings are: Administration, The Authority-Permissiveness Spectrum, Structure Versus Flexibility, Leadership, Group Cohesiveness, and The Relationship Between the Physician and His Individual Associate.

Administration

The physician finds himself an administrator in numerous settings in his clinical work, whether he be a public health administrator, responsible for the work of a local health department, or a practicing physician, marshalling the nursing and technician resources of a hospital ward for the care of his private patient. He is involved in tables of organization, legal responsibilities, health economics, the issuing of directives, and the making of decisions affecting the work of other professionals. When the table of organization in such situations follows the traditional structure of a hierarchy with an all-powerful director at the top and clearly designated channels of communication to him, there seems to be maximum efficiency in relationship on the surface if this structure is clearly followed. When acute medical and surgical problems are at hand, such a table of organization always has the prospect of gaining the best results and is indeed necessary for the handling of emergencies and disasters.

When, however, chronic disease or continuous health care is concerned, whether it be in the physician's office, in the hospital, or in the bulk of the work of modern public health, this hierarchic structure often runs into difficulties. The number of problem situations which come up in such time-protracted work are often temporarily solved by the setting of limited goals, or are marked by delay in decisions. In these instances, the physician-leader finds himself relying more upon the background and opinions of his associate workers or else discovers that he is pushed to maintain his role as a leader in the absence of the possibility of making immediate decisions. It is often here that he may unknowingly be threatened and may block the initiative of his associate workers. As a result, increased tensions may spring up in the group. Another factor is the natural inability of any physician in the year 1956 to know enough about all the details of medicine and its related fields to handle every contingency that arises. He may, at such a moment, have to relinquish his overt leadership to one of his paramedical associates who for that moment acts as a resource person for the clinical group.

I think that it is possible to view the medical team or situation as one which is not dependent upon a single conventional table of organization, but which demands a capacity within the physician-leader to shift to other types of administrative organization in order to meet certain problems. It is possible to understand this aspect better if one views administrative organization as a set of models, each with its respective functions. The traditional latticework or genealogic type model with a director at the top, division heads under him, and subsidiary workers under them has proved universally to be an efficient working arrangement for large organizations or for small group situations demanding immediate action and decision.

A common but incompletely conceived model is the axle and wheel, in which each member of the clinical team brings to bear upon the patient's problem his own specific type of work. Here the workers are like a revolving wheel around an axle, and in this situation the physician as the director collects and integrates the findings of all the participants. In our experience, such an arrangement impels the collecting of more data about the patient, but is not really a combined effort utilizing all the resources of each worker. We have found that the most effective concerted action of the clinical group is produced by a table of organization in which the roles and functions of each worker overlap, much as one might view a series of overlapping concentric circles like the Ballantine's Ale trademark. In such a plan, each worker finds that he need not fear to tread be-

yond the boundaries of his own discipline and is afforded the opportunity of expressing his initiative. This latitude does not mean that he moves into the heart of the other worker's discipline, but that he is free to share portions where disciplines overlap.

A typical example would be the hospital pharmacist who feels free to discuss with the physician the toxic action of a drug which the physician has prescribed for his patient if in that patient there has developed a toxic reaction to the drug. On our experimental ward we used this arrangement freely in the relationship between physician and nurse wherein the nurse was free to utilize her own initiative in perceiving meaningful segments of clinical history by practicing interviewing technics during nursing care of a patient. In a series of inservice training courses in mental health for public health officers and public health nurses, we found that it was possible for the nurses to feel free to bring to the health officer from the field suggestions which might contribute toward the solving of a public health problem in the district.

Authority — Permissiveness Spectrum

Szurek has admirably discussed this problem in the book previously cited. Here I will attempt to treat briefly an aspect of the problem of team relationship which is indeed a large one. The more highly structured and routinized an organization for a clinical team the firmer become the lines of authority. An authoritative arrangement, highly structured, brings to many a feeling of security and comfort, but at the same time it risks the danger of closure, obstruction to the free collecting of raw data, and the limitation of expressiveness and initiative. In fields such as general medicine and public health, in which multiple factors impossible to control tightly are part of the problem to be solved, rigid structuring and authority, either in consistent even doses or in large measure, may tend to interfere with the solution of time-protracted problems.

At the opposite pole of the spectrum from authoritativeness lies extreme permissiveness. License in the extreme seems to produce fragmentation of the clinical group, lack of certainty on the part of its members, and absence of meaningful focus upon the problem. The small group at work on a task will not tolerate extreme permissiveness, since it must have a leader in order to function and will often itself appoint a leader from its ranks. Some degree of license or permissiveness seems to be salutary, however, particularly in exploring a clinical or community problem. If the clinical group recognizes that its physician-leader fosters a certain amount of permissiveness with definite goals in mind, such as for the purposes of collecting as much raw data as possible and for stimulating participation by members of the clinical team, it will all the more tolerate the authority vested in the leader. Authority brings with it in human relations anywhere, whether it be in filling the role of a father, a physician, or a boss, a natural mixture of dependent feelings and antagonism toward the authority. The physician-leader, therefore, who can follow the golden mean in expecting his associate workers to be at times dependent upon him, while in other instances hostile toward him, can steer the way for the clinical group in a steady and consistent course without unnecessary, wasteful tensions and without sacrificing valuable data and solutions to problems.

Structure Versus Flexibility

Around the problem of his authority, the physician-leader may often feel threatened when it appears that his judgment and directives are coldly received or are met with subtle tension and antagonism. If he holds to the role of the omniscient director, he may be in for a large share of internal discomfort. If, on the other hand, he attempts to follow the principle of flexibility, viewing the various phases of relationship as a means to the end of solving the clinical or public health problem, his energies can be devoted more completely to the task at hand. For the leader (and for the follower), tight structure may mean more certain immediate security when all is in black and white and the milestones are clearly marked, but such a leader is analogous to the backfield man in football who can only hit the line again and again, whereas we would view as more effective the open field runner who is skillful at changing pace.

This opinion was born out on our experimental ward where the physician moved on the continuum between authoritativeness and permissiveness as the clinical situation demanded and permitted changes in administrative organization according to the clinical entity with which the clinical group worked. We have evidence to show that as a result there was less turnover of nursing and technical personnel, use of fewer drugs and procedures, and almost no readmissions of patients who had been treated under such a regime. Most of the problems among the members of the clinical

team and with exacerbations of symptoms in patients occurred when the leader moved too drastically toward either the pole of authoritativeness or that of permissiveness.

Leadership

It now seems apparent from this discussion that we would view the relationship of the physician to other workers of the team as that of a leader who functions not as an omnipotent director but as a guide for the worker group in the clinical or public health context. He places as primary the solving of the task at hand, even if it means concessions and sacrifices in terms of the traditional concept of the physician-leader. This method means that not only is his major objective a problem-solving one, but he also has a second primary goal of facilitating maximum integration and productiveness of his group. Our discussion suggests that in order to attain this goal he must at all times be a party to an ongoing self diagnosis of where at any moment his leadership lies on the spectrums of authoritativeness and permissiveness and of structure and flexibility. He will find also that his relationship with the other workers is most optimal when he allows the group under his guidance to make as many decisions as possible for itself relevant to its task. If he finds that the group cannot decide in instances which depend largely upon his professional experience and legal responsibility, he further proves himself the leader by shifting gears to an authoritative approach in which he himself determines the decision. When he has thus handled such ranges of possibility and then takes authoritative action, his associates accept this usually without negative aspects of relationship entering the picture.

Group Cohesiveness

The necessity of a close integration in the clinical group has been consistently implied. It has been pointed out that one of the major objectives of the physician should be the attainment of this cohesiveness. Such a working union indicates positive and constructive working relationships. We have already indicated certain administrative and leadership processes through which cohesiveness occurs. I should like now to elaborate briefly on still another principle or process to which already some allusions have been made. This principle is consideration for the status of each discipline outside of medicine. Many of the problems that exist in the public health and clinical team arise from an awareness of status differences. It has been postulated that physicians are finding their status and prestige threatened by the broadening of the field of medicine, increased knowledge of paramedical disciplines, and a more knowledgeable public which feels that it has a right to take a more active part in health affairs. If the physician works along the same table of administrative organization that has been traditional for him, he may consider that his status decreases as he allows the status of associate workers to increase. If he is not interested in status as much as he is in the task at hand, this relative position does not trouble him appreciably. If he views his role as that of a different type of a leader who acts as integrator rather than director, he may find that his status is not threatened at all, but is really enhanced.

If I may return to the example of our experimental ward, we found that if we set the maintenance of the cohesiveness of our clinical group as the first order of business, interpersonal relationships rarely became a significant problem in the task that we had to perform. This was accomplished through a conference twice a week in which physicians, nurses, aides, social workers, psychologists, and physical therapists sat down at a round table and discussed freely and openly the more significant current problems which affected the team as a whole. In such a workshop any one from any discipline could feel free to express his opinion as he saw fit without threat from any discipline which traditionally had been viewed as having more status than his own. Such procedure by virtue of its own experience produced a leveling of status in which respect was not sacrificed by any discipline while an optimal working relationship for the whole team was achieved. I have seen this plan subsequently practiced by a small county public health department and by a certain bureau in a state health department with remarkable effects.

The Relationship Between the Physician and His Individual Associate

It is recognized that our discussion has thus far dealt with the group aspects of physicians' relationship with other members of the team. The physician, as the leader of the group, also has individual responsibilities to his associate workers. He may be viewed by them as the final authority on many matters. As he and his associate consult together, he can be aware of the dependency-antagonism pattern in which the worker interacts with him in variable proportions.

The associate worker may reduce his tension by expressing subtle antagonism toward his chief in a reasonable fashion if the latter has the tolerance to accept this on the basis of its being like a physiologic mechanism that is not personally intended.

In general, the one-to-one relationship between physician and associate follows expert interviewing technics. The interviewee can be permitted the initiative in expressing himself on a charged topic while at the same time the goal of the interviewer is to allow focused ventilation while he listens and prompts. Many crises that occur in a public health unit are charged situations affecting two workers. Often a problem may ensue for one or both in terms of falling efficiency, neglect of reporting, absenteeism, sickness, or turnover. A conference between such a worker and the public health officer in which the latter "hears it out," watching for statements referring to another worker, is a useful method of choice. If ventilation on the other worker is then encouraged, this not infrequently may serve to correct the situation. It may be that the other person is someone outside of his group who may be a family member or another professional. If the health officer succeeds in getting his associates to express themselves this openly, it usually means that he has already demonstrated to them his willingness to assume a broad role in which, through a variety of situations, he has shown that he is not threatened.

Conclusion

I have presented here today what might be considered a frank exposition of a current problem which we all, as physicians, must meet in the present order of the practice of medicine and public health. Advances in our field have increased the complexity of our work and compel us to change methods and technics as we move toward more complex vistas in the battle against disease. This progress makes it necessary that we share our work with a larger number of professionals and laymen. Just as many times in the past physicians have been threatened by advances which require change in methods and philosophy—and I cite as an example the effect of antibiotics on the problem of tuberculosis—so it is natural now that we feel the threat to status and traditional method in terms of dealing with larger groups of people. This threat we can work through as we have others in our history by approaching it scientifically, as I have tried to do today.

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Discussion

Dr. W. Laney Whitehurst, Jacksonville: To discuss a paper such as we have just been privileged to hear is indeed a large order. To say that I have thoroughly enjoyed it would be the understatement of the year; yet, anything I might possibly add would be an anticlimax. I will say that seldom does one have the opportunity to hear so much said in so short a period of time.

Dr. Greenhill has not given us the solution to our problems, nor has he given us "pot" answers or "platitudes." Anyone who expected solutions for the complex problems we face today expected too much, for the millennium is not yet here.

Dr. Greenhill has pointed up the fact that we physicians may naturally feel threatened by the advances made by the paramedical sciences and the laity—advances which demand some changes in our traditional methods and philosophies.

He has helped us to view realistically the fears that beset us.

He has caused us to pause—to begin re-examination and re-evaluation of ourselves, our attitudes and our practices in the light of present day concepts.

He has suggested practical means, based on scientific evidence, whereby we may come to grips with the most pressing problem facing us as physicians today, namely, ourselves and our relationship to others.

We owe Dr. Greenhill a debt of gratitude. Without further comment I commend his remarks to you for your most thoughtful consideration and use.

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Horizons Unlimited

Francis H. Langley, M.D.
ST. PETERSBURG

It was the gay and delightful Sir Harry Lauder, famed comedian of other years, who used to tell of an old lamp lighter in a town of his native Scotland. At dusk each day the old man would put a ladder against a light pole and climb up to light the lamp. When he had lighted that lamp, he would climb down the ladder and carry it to the next lamp post.

"Finally," said Sir Harry, "the old man would be out of sight. But you could always tell which way he went by the lamps he had lit." So it is with education, and particularly with science.

On this auspicious occasion, it is an inspiration to look into the eager faces of this group of young Floridians. You represent a cross section of this nation's most precious possession—its talented youth. Which way are you going? How high up the ladder of science will you climb? What lamps will you light? Already you are ascending the lower rungs of the ladder of scientific progress, or you would not be here today. Your exhibits in this science fair mark you as young people of keen mind, using constructively the special talents with which you have been blessed. These endowments represent a challenge you cannot ignore, and fortunately you are beginning early to develop them.

We revere our forefathers for braving the great expanse of wilderness from which they built this great country, but we share the excitement of their pioneer life today only on the television or motion picture screen, and within the pages of a book. Geographically, the frontiers of our land have long since receded off shore into the Pacific Ocean, and the spirit that achieved this conquest remains forever enshrined in picture, song and story.

Yet there remain for you who are the youth of America today far broader horizons, luring you to adventure and discovery undreamed of by the founding fathers of our land. You can be pioneers now in the vast reaches of the wild and unmapped world of science, which far outstrip the conquered wilderness of the physical world. The inquiring mind of youth is delving into the unknown as never before. You who are capable and ambitious young people of scientific bent have the potentialities for adventure and discovery unknown to your predecessors and unshared even by your contemporaries. You stand on the threshold of Horizons Unlimited.

"We should all be interested in the future," said Charles F. Kettering, "because that's where we're going to spend the rest of our lives." The future of all of us in a very real sense is in the hands of our young folks. Its course will be largely determined by the lamps you light. The profession of scientist—whatever the branch of choice—is made to order for you. Ingenuity and inventiveness are distinctive qualities in American youth. Coupled with individual effort and free enterprise, they have made this country great. They are at the very heart of scientific endeavor. You young folks of talent and vision, you who are vigorous and progressive and full of wonderful constructive imagination, have a magnificent opportunity to help yourselves and to help America toward the better future that must be ours if we are to stay free and strong. Your eagerness to accept the challenge of the future is attested by your presence here.

As you contemplate that future with its unlimited opportunities in your particular field of science, and in other fields as well, you may thank God that you live in a country which remembers always that there is no substitute for the individual. This is the place where the communist and socialist governments alike, in the atmosphere that they create, fall down. Never forget that communism is based on a pattern of bloodshed, barbarism, suppression and slavery. Each individual, as someone has said, is "bound like a jungle-trapped deer in the vines of red tape." Lack of freedom is a built-in handicap throughout the communist system. As did Macbeth, the Reds discover that you can murder Banquo, but you cannot lay his ghost. You can murder Freedom, but the result stays with you, as witness Hungary.

Not so in this great land of ours where Freedom is our strongest force. We believe that knowledge is light, and fundamentally it is knowledge properly applied here in our free country that has given us the world's highest standard of living. It is here that, time after time, one man with the proper incentive and necessary spark, like Thomas

Address of the President of the Florida Medical Association presented at the annual awards ceremony of the Florida State Science Fair, held at the University of Florida in Gainesville, April 13, 1957, on the occasion of the first presentation of the Florida Medical Association Awards.

Edison and so many others, has set this country years ahead of itself. That is the history of mighty, free America. And history continues to repeat itself. It is you—the youth of the land—who will open new fields of knowledge that will build an ever more dynamic and prosperous national economy, who will keep America strong and free.

No field of scientific endeavor has more appeal, in my opinion, than medicine and the allied sciences. Medicine offers adventures of the mind unlimited, and rewards commensurate with so noble a calling. No branch of science needs to garner its share of America's wealth of young talent more than medicine, for its challenge is tremendous and the need for recruits is ever greater, especially in a state like Florida with its rapidly increasing population. It is particularly gratifying to the medical profession of our state, and of our nation, to know that two of every five finalists in the National Science Fair in recent years are now studying medicine or one of its allied fields in college. Their academic goals include medicine, medical technology, nursing, pharmacy, physical therapy, anatomy, psychology, bacteriology, chemistry, biology, and zoology. One of the great changes in medical education over the years has been the incorporation of the medical school within a university. The university influence on research and teaching methods has greatly advanced the state of the nation's health. This happy union of university and medical school is uniquely and ideally exemplified right here in our own University of Florida. Those of you who are attracted to the medical sciences and allied professions have exceptional opportunities for training in your own home state.

The romance of these sciences is intriguing, and discoveries and advances in one may have repercussions in others that reverberate down the corridors of time. The wind blowing in Sir Alexander Fleming's window was not the first harbinger of penicillin. Scientists had already observed that some bacteria destroy others. It was Fleming, however, who perceived that something in the wind had contaminated the plate cultures of staphylococci on his laboratory bench. His scientific curiosity aroused, he looked closely, and there fringing the outer edge was the pale blue mold that had killed the staphylococci.

Carelessly tossing a key on an undeveloped photographic plate covered with black paper, Wilhelm Roentgen turned on a cathode tube with which he was experimenting. When by mistake the plate was developed, there appeared on the negative the outline of the key. His scientific mind was quick to realize that the rays of the cathode tube had miraculously penetrated the black paper. True, he was branded a charlatan and bitterly opposed for contending that invisible rays could pass through an opaque substance, but he persisted until he eventually built the first X-ray machine.

Let us return now to the Scotland of our lamp lighter and hear the story of a boy prodigy of a century ago who lit a lamp for science and started a chain reaction of research that has pyramided to the present time. We find him, a youth of 18, at home from college on Easter vacation, and at work in the crude little laboratory he had rigged up in the attic. He was trying to make synthetic quinine from coal tar derivatives, but was rewarded only with a sticky black mass in the bottom of his test tubes. On cleaning out the tubes with alcohol, he noticed that one of them turned a beautiful delicate purple, a color which he thought might make a good dye.

He was right. By synthesizing the first coal tar dye, the boy chemist had made a vital discovery in organic chemistry. Soon this first important artificial dye in history became so fashionable that it lent its name to a whole period—the Mauve Decade. William Perkins became rich and was knighted by Queen Victoria. His discovery, however, had only begun to play its historic role in the drama of scientific progress.

Coal tar, the source of the aniline oil used in his experiments, previously discarded as waste, now became a key material as a source of high quality dye. Far more important, the youthful scientist had tapped the wellspring of organic chemistry, a science deeply affecting the lives of all of us for it embraces the infinite combinations of carbon with hydrogen, oxygen, nitrogen and other elements—complex structures basic in all life.

Pasteur's germ theory of disease is regarded as one of the 10 greatest discoveries in the history of mankind. But suppose Perkins had not made his discovery first. Pasteur's research would not have been possible, for it depended upon the property of coal tar dyes to stain bacteria selectively, thereby making possible the accurate study of microbes under the microscope.

Perkins's discovery gave impetus to research which produced some of the compounds that have had a key role in the medical advances of the twentieth century, as well as in many other fields. Medicinal chemicals such as sulfonamides, hor-

mones, penicillin, and the whole array of "wonder drugs" are among the contributions of present day chemistry. The chain reaction continues. The boy scientist's unrewarded attic search for synthetic quinine to cure one human ill has helped to reshape man's destiny.

Science has become infinitely more intricate and purposeful than when young Perkins made his dramatic discovery a hundred years ago. Who can say what discoveries will be made by scientists endowed with training, skill and imagination in the atomic age now dawning? Back in 1922, a young Danish scientist received the Nobel Prize in Physics for presenting, at the age of 28, a basic theoretical work on the structure of the atom. Thereby, he contributed materially to clarification of the basic concepts of quantum physics and opened up a whole new era in the field of atomic physics. Just the other day, this distinguished atomic physicist and teacher, Professor Niels Bohr, was named the recipient of the first $75,000 Atoms for Peace Award. He expressed the "fervent hope that the progress of science might initiate a new era of harmonious cooperation between nations." What part will you have in bringing about that new era for the benefit of all mankind? In the years to come, will the world be able to tell which way you went by the lamps of science you have lit?

ABSTRACTS

Glycogen in Invasive Squamous Carcinoma of the Uterine Cervix. By Alvan G. Foraker, M.D., and Genevieve Marino. Am. J. Obst. & Gynec. 72:400-403 (Aug.) 1956.

Absence of glycogen in squamous carcinoma of the uterine cervix is almost axiomatic in gynecologic pathology. Two studies, however, in which Dr. Foraker participated in recent years suggested that glycogen may be present in squamous carcinoma of the cervix. These studied prompted an investigation into the glycogen staining reaction of 21 examples of invasive squamous carcinoma in this site. Variable degrees of glycogen staining were demonstrated in 13 of these 21 examples of invasive squamous cell carcinoma of the uterine cervix. Caution in interpreting the absence or presence of glycogen staining as a highly valid criterion in the diagnosis of cervical carcinoma in smears or tissue sections is advised.

The Two-Hour After-Meal Urine Test for Diabetes Mellitus. By Sidney Davidson, M.D., and Richard F. Kidder, M.D. Am. Pract. 7:564-565. (April) 1956.

The purpose of this article is to urge the use of a simple test for detecting diabetes mellitus which can be performed routinely in the office of the average physician. It requires little cooperation on the part of the patient, and its use has been fruitful in the hands of the authors. This is the two-hour after-meal urine examination which has been routine in their practice for more than a year. They describe the method and present representative cases in which routine analyses gave negative results, but the diagnosis of diabetes was made possible by this test.

Splenic Infarction in Sicklemia During Airplane Flight: Pathogenesis, Hemoglobin Analysis and Clinical Features of Six Cases. By Royal Rotter, Captain (MC), A.U.S., William F. Luttgens, Captain (MC), A.U.S., Wesley L. Peterson, Captain (MC), U.S.A.F., Albert E. Stock, Captain (MC), A.U.S., and Arno G. Motulsky, M.D. Ann. Int. Med. 44:257-270 (Feb.) 1956.

Splenic infarction precipitated by airplane flight was observed in five Negroes and one Puerto Rican with sicklemia. The six cases here reported indicate that this problem has become of importance in aviation medicine. Hemoglobin analysis in this series revealed that three of the patients had sickle cell trait, two had sickle cell-hemoglobin C disease, and one had sickle cell-thalassemia disease (microdrepanocytosis). Suggested factors having a role in precipitating this syndrome are hypoxia, amount of sickling (S) hemoglobin (more than 40 per cent in all six cases), and peculiarities of the splenic circulation, namely, slowing of blood flow in the pulp and poor collateral blood supply between splenic arterial branches. It is recommended that persons with sickle cell trait should not fly at high altitudes in unpressurized airplanes unless a source of oxygen is available and that those with splenomegalic sickle cell anemia, sickle cell-thalassemia disease and sickle cell-hemoglobin C disease should not fly unless ground level air pressure can be maintained.

The authors regard nonsurgical symptomatic treatment of flight-induced splenic infarction as probably sufficient in most cases, although sple-

nectomy may be required in selected instances. They observe that the occurrence of splenic infarction in persons with the sickle cell trait emphasizes that this common condition can no longer be considered entirely benign. Their suggestion is that the Armed Forces institute a paper electrophoretic screening program for the detection of sicklemia among Negro and Puerto Rican military personnel on induction, and they recommend similar screening tests for any Negroes who fly repeatedly.

Hyaline Membranes in the Lungs of Premature Infants. By Wayne S. Rogers, M.D., and Peter Gruenwald, M.D. Am. J. Obst. & Gynec. 71:9-15 (Jan.) 1956.

Presented here is a study of the autopsy findings and histories of 56 newborn infants, in whose lungs hyaline membranes were present. Among the various factors in the mothers and offspring which are reviewed, prematurity and maternal antepartum bleeding appear to be clinically significant. The authors point out that it is important to distinguish the frequently occurring atelectasis with hyaline membranes of premature infants from vernix membranes of infants born at term. In premature infants a peculiar type of atelectasis of the alveoli occurs in association with dilatation of the terminal air passages. The latter may or may not be lined by hyaline membranes. This type of atelectasis appears to be favored by some unknown factor associated with prematurity. It is probable that this entity is more significant than the hyaline membranes which are inconstantly associated with it, the authors conclude. They are also of the opinion that hypoxia, shock, vascular injury, and pulmonary edema are probably important factors contributing to the death of these infants, either by enhancing their pulmonary lesions or by other effects.

Diverticulum of the Appendix. By H. Clinton Davis, Captain, MC, USAR, Taufick E. Bendeck, Captain, MC, USAR, Edward A. Hanske, Captain, MC, USAR. U.S. Armed Forces M. J. 7:343-347 (March) 1956.

Diverticula of the vermiform appendix occur more frequently than is generally conceded. They are usually of the acquired variety and are most often located at the distal portion of the appendix on the mesenteric side. Appendiceal diverticulitis is an especially severe type of appendicitis. The authors observed four cases in a period of two years at one hospital in which seven appendiceal diverticula were found. All patients in this series had an appendectomy for acute appendicitis, and in each instance a severe inflammatory process was present in the appendix. In each patient the distal half of the organ was involved, and all diverticula were located on the mesenteric border. A diverticulum was suspected by the surgeon in one case because of the thickened mesoappendix, but in the others the diverticula were found on gross examination by the pathologist. Multiple diverticula were found on two occasions. In only one case was a history suggestive of previous appendicitis obtained. Age and sex appeared to have no relationship. Three of the four patients in this small series were men; however, approximately 10 men to one woman were operated on for acute appendicitis during the period of this study. Since these four cases represent a sample from a total of just over 400 consecutive appendectomies, the incidence of diverticulum of the appendix was approximately 1 per cent.

Plasmacytoma of the Gastro-intestinal Tract. By James W. Merritt Jr., M.D. Ann. Surg. 142:881-888 (Nov.) 1955.

Extramedullary plasmacytoma is a relatively rare tumor, but its presence has been reported in many different areas of the body. It occurs most commonly in the conjunctiva and upper air passages. The author reports two cases of plasmacytoma of the gastrointestinal tract and tabulates 17 others reported in the literature, making a total of 19 reported cases. In this series males predominated over females by a ratio of 2:1. There was no clear correlation between bone marrow studies, Bence Jones protein, serum globulin levels, and the presence of gastrointestinal plasmacytoma. It was difficult or impossible to determine the prognosis from the histologic appearance of the tumor. The possibility of multicentric origin of such tumors, as suggested by some authors, seemed to be borne out by the simultaneous occurrence of plasmacytoma in two different areas in the author's first case.

Members are urged to send reprints of their articles published in out-of-state medical journals to Box 2411, Jacksonville, for abstracting and publication in The Journal. If you have no extra reprint, please lend us your copy of the journal containing the article.

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A New Way of Dying

This intriguing title is that of a widely circulated article[1] by an anonymous author. In it she describes vividly the agony of her husband's death, prolonged by the "miracles" of modern medicine—the intravenous feedings, the gastric suction, the oxygen bubbling on its way to the nasal catheter, and the never-ending series of injections. She recounts the lack of comfort she experienced from the well worn phrases "the patient is holding his own" and "we're doing all we can," and makes clear her conviction that death is robbed of its dignity by the impersonal and mechanistic measures found in the modern hospital. Through the article runs the theme that the patient is struggling to reach "the other shore," only to be dragged back time and again by the doctor's merciless efforts. These efforts are interpreted as "a ghastly imposition against God's will."

This is indeed a serious indictment. The physician, who must answer the ever recurring problem of what pain-producing measures are necessary to heal the patient, finds himself accused of being Antichrist if the patient dies despite the treatment. How can it be that medical advances are interpreted as means of challenging and thwarting God's will?

Part of the answer is to be found in the emotional defenses erected by those who watch their loved ones suffer. The widow who wrote the article in question interpreted her husband's struggle as one toward release and death rather than toward life, but actually few sufferers really want to die. Those who watch desire the patient's death because they cannot endure the distressing spectacle. Yet, they cannot admit to consciousness their own wish for relief and assume it is the patient who wishes to die. All measures which postpone the desired end are therefore interpreted as undesirable and evil.

The remainder of the answer lies in the attitude and actions of the physician. We all know of "hopeless cases" who recovered, perhaps by modern medicine alone, perhaps by faith and prayer, or perhaps by a combination of both. Some Christian physicians are not ashamed to admit to a distraught patient and family that they, too, pray for the patient. Most physicians would prefer to leave moral and religious interpretations to a clergyman. None of us should be hesitant in suggesting that the counsel and support of the patient's priest, pastor, or rabbi be sought in all cases of serious illness. In this fashion, the

physician can make clear his position as God's servant and ally rather than as His antagonist.

The thoughtful physician would do well to reexamine his own actions in handling such a case. Attention to the patient's comfort is no less important than attention to fluid and electrolyte balance in the over-all care of the patient. Straightening the pillow, placing the bell cord within reach, and stopping a minor yet irritating itch are more potent psychotherapeutic tools than the injections and intravenous fluids which the physician has ordered. Relief of pain, mental and physical, is still our primary concern. Let the miracles of modern medicine be dispensed with mercy and discontinue the tubes, catheters, and needles as soon as it is deemed safe. It should be apparent to the patient and his family that it is the man, as well as his disease, who occupies our attention.

There is no easy nor universally applicable answer to the problem of therapy in the critically ill patient. We would, however, do well to keep in mind the advice of Lord Horder, physician to King George V: "Be it observed that the good doctor is aware of the distinction between prolonging life and prolonging the act of dying. The former comes within his terms of reference; the latter does not."

1. The Atlantic Monthly, January 1957; reprinted in Reader's Digest, March 1957.

Florida Medical Association Awards at Florida State Science Fair

Participation by the Florida Medical Association in Florida's science fair program was initiated this year with the announcement of two special awards to be presented during the Florida State Science Fair, which was held in Gainesville at the University of Florida on April 11, 12 and 13. The Association established a policy of making these awards annually to students whose exhibits show the best aptitude for the medical sciences. They are for winning exhibits in the junior and senior divisions of the science fair. The junior division includes students from grades seven through nine and the senior division from grades 10 through 12.

Designated the "Florida Medical Association Awards," the awards consist of special citations and $75 and $50 in cash for the senior and junior divisions, respectively. The winning students also are granted the privilege of having a special guided tour of the University of Florida College of Medicine and an opportunity to discuss their scientific fields of interest with appropriate medical school faculty members. The purpose of the awards is to encourage promising junior and senior high school students to enter the field of medical science, and the winners are selected by a committee from the Association.

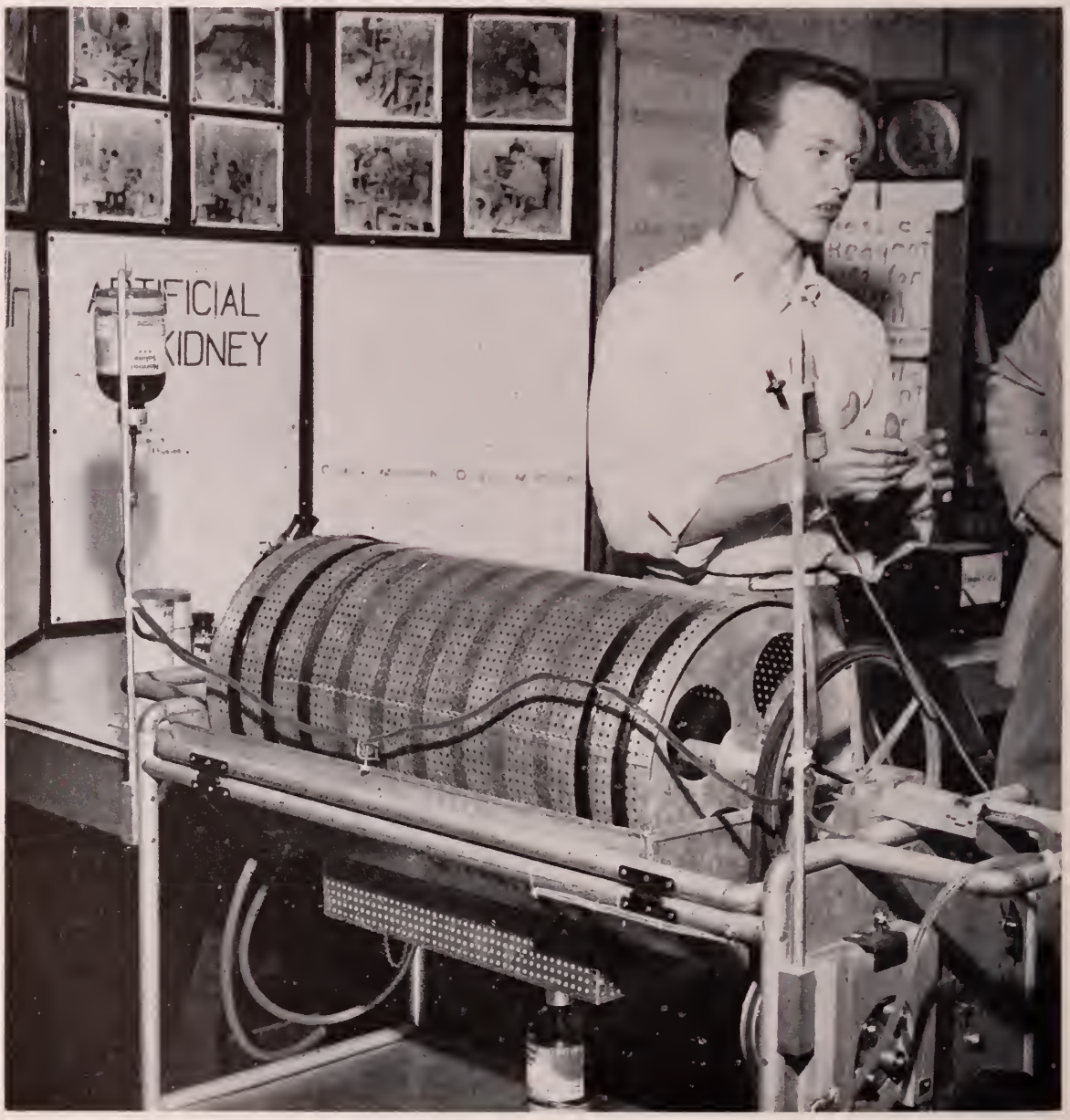
At the awards ceremony on April 13, the Association's first senior award went to Norman S. Kimmey of Melbourne High School, Melbourne, for his exhibit entitled "Artificial Kidney." Carol Ann Grizzard of Lakeland Junior High School, Lakeland, won the junior award for her exhibit entitled "Statistical Survey Proves Immunization Is Effective." The presentation of the awards was made on behalf of the Association by President Francis H. Langley of St. Petersburg. The Citation which accompanied the cash awards was issued "In Commendation of an Exemplary and Original Exhibit in the Field of the Basic Medical Sciences and Health Displayed at The 1957 State Science Fair, Gainesville, Florida."

After presenting the two awards, Dr. Langley announced that the Judging Committee was greatly pleased with the large number and excellent quality of the medical scientific exhibits; in fact, one member of the committee was so impressed that he arranged to present in the name of the Association, four honorable mention awards of $10 each from an anonymous source. The winners of these awards in the senior division and the titles of their exhibits were: Barry A. Maxwell of Winter Haven High School, Winter Haven, "Study of Adrenal Transplants in Adrenalectomized Animals;" William Brogden Jr., of Winter Haven High School, Winter Haven, "Antibodies Against Animal Tissue;" and Selma Anderson of Melbourne High School, Melbourne, "Vitamin Deficiency as Related to Blood Calcium and Bone Analysis." In the junior division, Jay J. Pfeiffer of Cocoa Junior High School, Cocoa, received an honorable mention award for his exhibit entitled "Nutrition."

The Association's Judging Committee was composed of Dr. George T. Harrell Jr., Dean of the College of Medicine of the University of Forida, Chairman, Dr. Allen Y. DeLaney, Dr. J.

Maxey Dell Jr., and Dr. Samuel P. Martin, all of Gainesville. They were confronted with a formidable task in choosing award winners for aptitude for the medical sciences because of the wealth of material. Out of a total of 193 exhibits, 27 qualified for judging in this category in the senior division and 9 in the junior division.

Science fairs at local, state or regional, and national levels have in recent years become popular stepping stones to youth achievement in science. In 1956 more than 187,000 students participated in local fairs which were visited by almost 964,000 persons. The regional or state fairs with 31,240 exhibits from the preliminary local fairs drew an attendance of 718,990 persons. At the 1956 National Science Fair, 213 boys and girls from 110 regional fairs in 39 states and the District of Columbia competed for top awards. This fair was estimated to be over 13 times larger than the first exposition held just seven years earlier. It reflects the comparable growth of local and regional fairs. The medical profession should note with particular appreciation that two of every five national finalists in recent years are now in



Norman S. Kimmey of Melbourne High School, Melbourne, winner of the Florida Medical Association's first senior award in the Florida State Science Fair, and his outstanding exhibit entitled "Artificial Kidney."

college studying medicine or one of its allied fields.

Successful fairs require the assistance, advice, and financial backing of a local sponsoring group. Until three years ago only three fairs were sponsored by medical societies. The phenomenal growth of the movement has brought such rich rewards in youth counselling and community relations that today the medical profession throughout the country is taking a spirited interest. The Association urges its component county societies to foster the movement at the local level and believes that its participation at the state level will be a source of gratification to all of its members.

The address of Dr. Langley on the occasion of this first presentation of the Florida Medical Association Awards, entitled "Horizons Unlimited," is published in the scientific section of this issue of The Journal.

Contributions to Medical Schools During 1956

More than half of the $2,247,425 contributed directly to medical schools by physicians during 1956 was unrestricted. The remaining amount was restricted for the teaching budget, a specific department, the building fund, research, scholarship and student aid, library, endowment, and miscellaneous purposes. Specifically, in the three highest categories the figures were $1,299,160, unrestricted, in 34,580 contributions; $565,927, for building funds, in 3,697 contributions; and $104,014, for endowment, in 2,048 contributions. In all, 44,765 contributions totaling $2,247,425 were made by physicians directly to their medical schools. In addition, 39,892 physicians contributed $1,072,727 to the American Medical Education Foundation. Many gave to both the Foundation and their schools, or gave to more than one school. The 1956 tabulations are believed to be the first accurate reflection of alumni giving that the Foundation has been able to publish.

In Florida, 73 contributions amounting to $4,641 were made to the Foundation, and the sum of $31,259 was contributed by 880 alumni to their schools. The total amount contributed by physicians in the state was $35,899.

The 1956 contribution of the American Medical Association was $225,000. The final figures were 84,657 contributions from physicians totaling $3,320,152, made to their medical schools and to the Foundation.

In addition, the nation's 82 medical schools benefited last year by nearly two million dollars from lay sources. The National Fund for Medical Education received $1,862,016 in 1956 from 1,737 business and industrial organizations. In 1955 the total was $1,693,048 from 1,525 companies. Heading the list were 73 life insurance companies with $313,702; second were 51 pharmaceutical companies with $198,205; and third were 47 petroleum and natural gas companies with $190,504. Twenty automobile companies gave $132,900. Contributions from 67 chemical companies amounted to $123,930, and 67 iron and steel companies gave $120,320.

From sources within and without the medical profession, the medical schools of the country received $5,182,168 in contributions last year, a steadily growing figure to meet an urgent need and a sound investment in the future health and well-being of the nation.

Graduate Medical Education

Hematology Seminar
June 20-22

The Seminar on Hematology to be presented by the Division of Postgraduate Education of the College of Medicine of the University of Florida, in cooperation with the Florida Medical Association and the Florida State Board of Health on June 20-22 will be the first postgraduate medical seminar to be held at the Science Building of the College of Medicine in Gainesville. The faculty for this seminar will be headed by Dr. Steven O. Schwartz, Associate Professor of Medicine at the Northwestern University Medical School, and will include Dr. Jacob Neber, Clinical Assistant Professor in Medicine at the University of Miami School of Medicine in Miami, Dr. Sanford A. Mullen, Pathologist at St. Vincent's Hospital in Jacksonville, and Dr. John B. Ross, Medical Director of the Jacksonville Blood Bank in Jacksonville. Programs with an application blank for advance registration have already been mailed to all physicians of the state. Additional programs and information may be secured by writing the Division of Postgraduate Education, 1625 Riverside Avenue, Jacksonville 4.

Annual Graduate Short Course
June 24-28

The Twenty-Fifth Annual Graduate Short Course will be held this year on June 24-28 at the Science Building of the College of Medicine of the University of Florida in Gainesville. It

will be presented as usual under the direction of the Division of Postgraduate Education of the College of Medicine of the University, in cooperation with the Florida Medical Association and the Florida State Board of Health. Programs have been mailed to all physicians together with a brochure containing motel, hotel and travel information.

The Division of Postgraduate Education invites the physicians of Florida to take this opportunity to visit its new office at the College of Medicine, to meet the faculty, and to become better acquainted with its plans and purposes as well as to tour the beautiful new Science Building of the College of Medicine. Tours will be made through the building during these two seminars for those who wish to see it.

The May issue of The Journal carries the program and full schedule for the Short Course and also for the Seminar on Hematology.

First American Congress on Legal Medicine and Law-Science Problems Chicago, July 8-20, 1957

A unique training program in the field of Legal Medicine and Law-Science problems, known as the First American Congress on Legal Medicine and Law-Science Problems, will be conducted by the Law-Science Institute at the Hotel Morrison in Chicago the second and third week in July 1957. The Law-Science Institute, sponsored by the Schools of Law and Medicine of The University of Texas, will be aided in this ambitious summer educational project by the Law-Science Academy of America and the Law-Science Foundation of America, charitable, nonprofit corporations organized by leading American trial counsel to carry out all phases of research, teaching, education, and publications designed to advance Law-Science integrations.

The Congress will contain features of great practical interest and value to lawyers and physicians. For the first time, this summer effort of the Law-Science Institute is being publicized to both professions. This season the Congress with its rich variety of instruction should have particular appeal to all members of the medical profession. It will offer multiple choices relating to trauma and disease and medicolegal aspects of the various specialties. In addition, there will be various evening sessions devoted to "Legal Problems in the Practice of Medicine." Doctors who attend will qualify for their Law-Science Certificate for the first week and the second week, but physicians will be permitted to attend the Advanced Course during the second week, even if they have not previously completed the Basic Short Course.

The regular Basic Law-Science Short Course on "Legal Medicine and Elements of Medicolegal Litigation" will be offered during the first week, beginning on Monday, July 8. This intensive indoctrination course will be invaluable to all physicians who have any connection with civil litigation from time to time. During the second week, July 15-20, advanced instruction will be offered in medicolegal aspects of personal injury problems. During the two week period, between 125 and 150 lecturers will take part in the Congress, drawn from the ranks of eminent medical specialists throughout the nation and top trial lawyers from both sides of the Bar. Interested physicians may address Hubert Winston Smith, LL.B., M.D., Director, Law-Science Institute, The University of Texas, Austin 12, Texas.

Business Management Featured in New Motion Picture Series

A series of 10 film presentations dramatizing the business problems of starting a new practice is now being released by Mead Johnson & Company for showing to medical students, interns and residents. The first of its kind, the copyrighted series is entitled "Business Management in Medical Practice" and consists of the films with accompanying commentaries by specially trained Mead Johnson representatives. Showings will be available to medical teaching centers and hospitals.

The first film, "Where Should I Practice?" was released April 1. The second and third films, "Financing the New Practice" and "Solo, Partnership, or Group Practice?" are scheduled for release about July 1. Other films in the series, which will be released individually at appropriate intervals, are: "How to Establish Proper Fees and Promote Collection," "How Much Liability, Property and Health and Accident Insurance Do I Need?" "Doctor-Patient Relations . . . Public Relations," "Personnel Selection and Training," "A Personal Life Insurance and Basic Estate Program" and "Office Layout and Design."

Each topic is presented as a case history, combining actual experiences of a number of physicians as reported by an advisory panel. All are designed to give a preview of basic business ques-

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of the

Florida Medical Association

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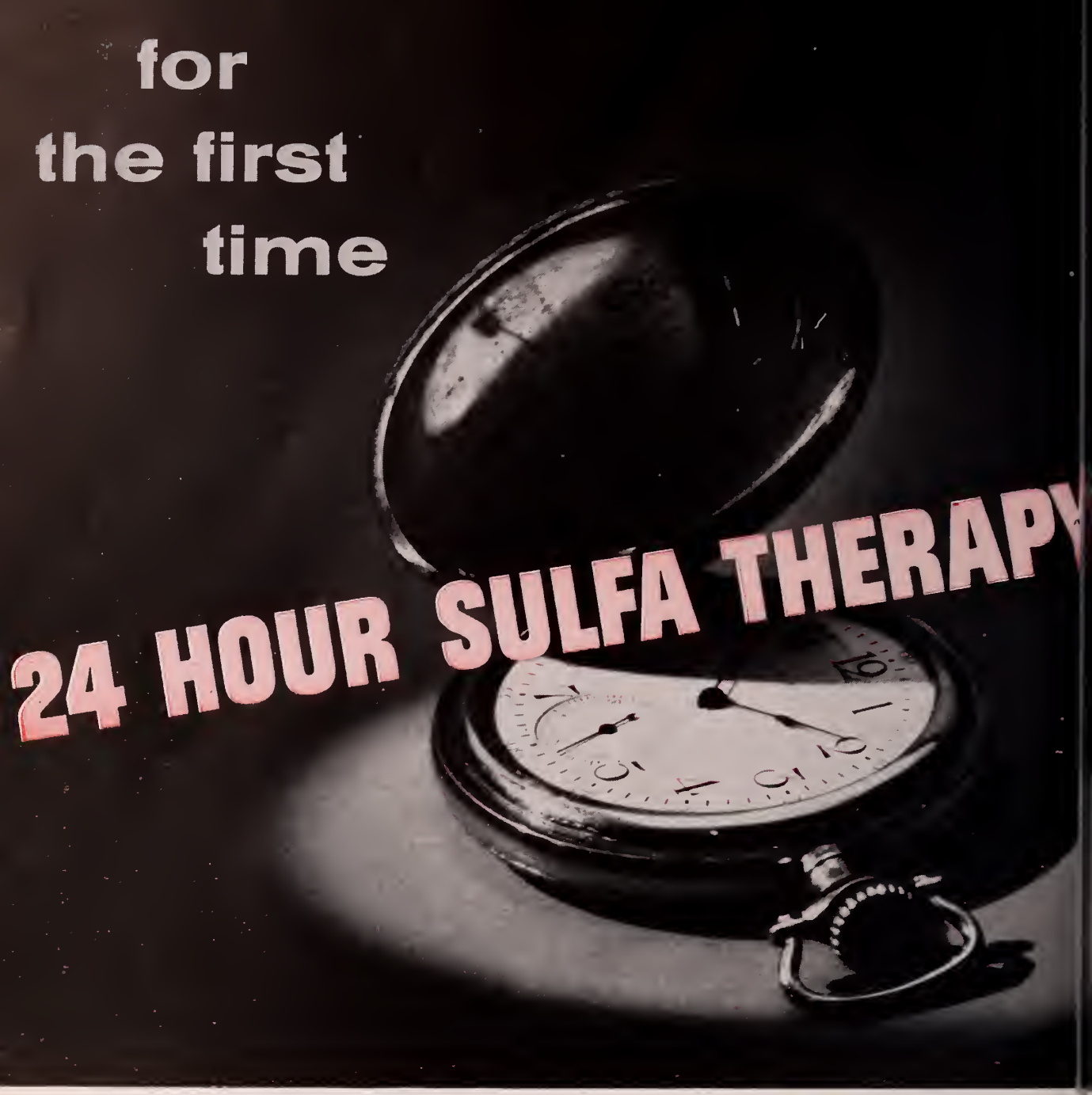

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FOR POSITIVE DIURESIS

ROLICTON®

Brand of Amisometradine

• oral b.i.d. dosage

• continuous control of edema

The new, highly effective oral diuretic, Rolicton, greatly simplifies the task of maintaining an edema-free state in the patient with congestive heart failure. Rolicton meets the criteria for a dependable diuretic: continuous effectiveness, oral administration and clinical safety.

In extensive clinical studies the diuretic response clearly indicates that a majority of patients can be kept edema-free with Rolicton. In these investigations it was noted that side reactions were uncommon. When they did occur they were usually mild.

In most edematous patients Rolicton may be employed as the sole diuretic agent. When used adjunctively in severe cases, Rolicton is also valuable in eliminating the "peaks and valleys" associated with the parenteral administration of mercurial diuretics.

One tablet of Rolicton b.i.d., after meals, is usually adequate for maintenance therapy after the first day's dosage of four tablets. Some patients respond well to one tablet daily. G. D. Searle & Co., Chicago 80, Illinois. Research in the Service of Medicine.

*Trademark of G. D. Searle & Co.

SEARLE

(Continued from page 1220)

tions young doctors should explore before entering practice. Presentation of an individual film requires about half an hour. Following it, a booklet on the topic covered will be distributed and questions will be sought from the audience.

Korean Need for Medical Literature Has Been Met

The American-Korean Foundation and the United States Army Medical Service have announced the discontinuation of their joint project of shipping medical books contributed by individual physicians, medical schools, hospitals and state and local medical societies to Korea.

Books should not be sent to the Sharpe General Depot in California as in the past for facilities no longer exist for packing and transshipping to Korea.

In making the announcement, Howard A. Rusk, M.D., President of the American-Korean Foundation, said, "the response of physicians and medical groups throughout the country for our appeal for books for Korean medical schools has been so generous that further contributions are not needed." As a result of this program, Dr. Rusk stated, over 77 tons, valued at $76,000, of medical texts, references and periodicals have been shipped to Korea for distribution to Korean medical schools.

OTHERS ARE SAYING

Editorially Speaking

A few nights ago your Editor had a nightmare. He dreamed that Blue Cross had gone under and had failed. With no competition, profit-making companies had doubled and tripled their premiums for hospitalization insurance so that only about one-fourth of the public could afford to buy the policies.

There was no longer any trouble about getting a patient into any hospital in town. With half the hospital beds in town standing idle, any patient who could afford to pay his own way, or who had one of the expensive policies that paid a part of the bill was given the V. I. P. red carpet Rx.

Physicians were going in debt because collections had fallen off so badly that expensive offices and equipment contracted for in the mid '50s could not be paid for. The few people who could afford to go to the hospitals and also pay their physicians were in such a minority that what little they paid could not bridge the gap. Most folks paying their own hospital bills had little or nothing to use to pay their physicians' accounts. No, this wasn't 1930; it was 1960.

The death rate was going up because sick folks could not afford hospitalization and people were writing to Washington. The Bolling-Hennings bill for prepaid federal health insurance to cover all illnesses, hospitalization and medical fees had passed the House and hearings in the Senate indicated that President Eisenhower and his entire administration favored the public's demand for the bill; except for two or three diehards it was expected to pass the Senate by voice vote. It would immediately be signed by the President, emergency clause and all.

Then, as in all good dreams as well as many movies and T. V. shows, the flash backs showed why it had all happened. It showed that the physicians had killed their own golden goose, the one they had conceived and brought forth into the world.

The scene was a physician's office. Patients came and went. Diagnoses were made and advice given. Part of every record carried the question,

"Do you have Blue Cross?" It was strange how the answer, "Yes," seemed to affect the physician. Those who had insurance called their own turn. If they wished to go into the hospital for tests, a few days rest or for a prolonged pre-operative stay for minor surgery, the physician acquiesced. He put up no argument or debate. The physician just said, "All right, I'll arrange for it. After all, you have Blue Cross."

The scene shifted to another office. Here the physician was in earnest debate with a patient. The doctor said, "But you don't need to go into a hospital. I can do all those tests right here." The patient said, "Listen, doctor, why should I pay you for these tests when my insurance will pay for them in a hospital? And besides I need a few days rest. If you won't put me in a hospital, I'll find somebody else who will."

Again the scene shifted. It was the next day. This doctor was walking down the hall of his favorite hospital. "Hi, Doc," came a cheery call from a room . . . and sure enough, there was the patient who had found someone else to supervise his rest and to approve the bill to be sent to Blue Cross.

Then the dream became chaos, as dreams do. "Yes, you can." "No you can't." "But sure, you should be able to take advantage of your Blue Cross." "Sure." "Yes." "But you shouldn't." "If you don't someone else will." Faces came rushing, rushing, shouting, grimacing . . . a real Greek tragedy.

And the fade-out . . . a goose flat on its back, eviscerated, and a lonely physician holding an ordinary gizzard.

Some may say that the moral really is that the public did the carving. That is the easy way out. After all, who should tell the public of the harm being done? None other than the physician, of course.

G. Wilse Robinson, Jr.
Weekly Bulletin
Jackson County Medical
Society, Kansas City, Mo.

Proceedings
Eighty-Third Annual Meeting
Florida Medical Association

The proceedings of the Eighty-Third Annual Meeting of the Florida Medical Association are scheduled for publication in the July issue of The Journal. The President's address is also scheduled for publication in July.

EVERY WOMAN
WHO SUFFERS
IN THE
MENOPAUSE
DESERVES
"PREMARIN"®

widely used
natural, oral
estrogen

AYERST LABORATORIES
New York, N. Y. • Montreal, Canada
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specifically for reduction of overweight

PRELUDIN®

(brand of phenmetrozine hydrochloride)

"...a highly effective and safe appetite suppressant..."[1]

Based on clinical reports, PRELUDIN produces more than twice the weight loss achieved by patients receiving a placebo.[2] It is singularly free of tendency to produce serious side actions, as well as stimulation.[1-3] PRELUDIN imparts a feeling of well-being that encourages the patient to cooperate willingly in treatment.[1-3]

The reduced incidence of side actions with PRELUDIN makes losing weight more comfortable for the average patient, facilitates treatment of the complicated case and frequently permits its use where other anorexiants are not tolerated.[3]

Recommended Dosage: One tablet two to three times daily one hour before meals. Occasionally smaller dosage suffices. On theoretical grounds, PRELUDIN should not be given to patients with severe hypertension, thyrotoxicosis or acute coronary disease.

(1) Holt, J. O. S., Jr.: Dallas Med. J. 42:497, 1956. (2) Gelvin, E. P.; McGavack, T. H., and Kenigsberg, S.: Am. J. Digest. Dis. 1:155, 1956. (3) Natenshan, A. L.: Am. Pract. & Digest Treat. 7:1456, 1956.

PRELUDIN® (brand of phenmetrazine hydrochloride). Scored, square, pink tablets of 25 mg. Under license from C. H. Boehringer Sohn, Ingelheim.

GEIGY Ardsley, New York

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from the places where it matters most... proof that Entero-Vioform® stops

- infectious diarrhea
- amebic dysentery

Reports from areas where infectious diarrhea and amebic dysentery are particularly prevalent continue to reflect preference for Entero-Vioform therapy. This well-tolerated, virtually nontoxic, antidiarrheal agent can be useful in *your* day-to-day practice to prevent or control these disorders. You can recommend it with assurance, particularly to protect travelers from the dangers of different foods and drinking water.

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"Never judge a book
by its cover" . . .
nor a malpractice policy
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Specialized Service
makes our doctor safer

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BRAND OF MECLIZINE HYDROCHLORIDE

prevents nausea,
vomiting and vertigo
associated with
vestibular disturbances

*Trademark

STATE NEWS ITEMS

District IV of The American College of Obstetricians and Gynecologists will meet in Washington, D. C., October 4-5. Florida is one of seven states comprising the District. Dr. Frank R. Lock, Bowman Gray School of Medicine, Winston-Salem, N. C., is District Chairman, and Dr. Robert H. Barter, 901 23rd St., N. W., is chairman of the program for the meeting.

The Hunter's Fall Medical Meeting sponsored by the South Dakota Medical Association will be held at Mitchell, S. D., during the first five days of pheasant hunting season in October. The program is set up for out-of-state doctors and will feature morning scientific sessions, afternoon hunting and evening scientific and social sessions. Registration fee is $100 which will cover the out-of-state hunters license, hunting guides, reserved hunting areas, several social events and the scientific program. For details and reservations, con-

(Continued on page 1240)

CLASSIFIED

Advertising rates for this column are $5.00 per insertion for ads of 25 words or less. Add 20c for each additional word.

WANTED: Physician with Florida license. Interest in Physical Medicine and Geriatrics. State qualifications in writing. The Miami-Battle Creek, Miami Springs, Fla.

WANTED: Specialist in Obstetrics and Gynecology to associate with group in Dade-Broward area. Board man preferred. Write age, training, chronology of medical experience, reference. Write 69-222, P. O. Box 2411, Jacksonville, Fla.

INTERNIST (Cardiology): Desires association with established physician or group. Florida license. Diplomate. F. A. C. P. Middle aged. Protestant. Write 69-223 P. O. Box 2411, Jacksonville, Fla

INTERNIST WANTED: Established certified internist desires associate. Florida license, certified or board eligible. Give full background in first letter. Write 69-224, P. O. Box 2411, Jacksonville, Fla.

OBSTETRICIAN-GYNECOLOGIST: Completing residency July 1957. Florida license. Family. Age 30. Category IV. Desires group practice or association. Write 69-225, P. O. Box 2411, Jacksonville, Fla.

WANT TO BUY: Used binocular microscope suitable for medical student. Write 69-227, P. O. Box 2411, Jacksonville, Fla.

LOCUM TENENS: July 1, 1957 to January 1, 1958. General Practitioner to associate with same. Suburban Jacksonville. To future association as agreed. Write 69-229, P.O. Box 2411, Jacksonville, Fla.

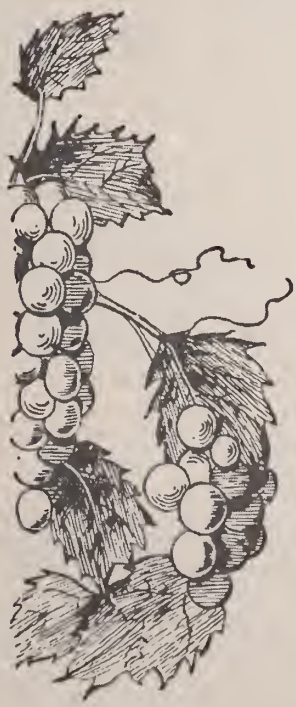
GENERAL PRACTITIONER: New medical building and apartment absolutely rent free until established, then reasonable.Write Archie Edwards, 2030 Oak Terrace, Sarasota, Fla. Telephone Ringling 7-3862.

WINE HAS A PLACE

in MODERN MEDICAL PRACTICE...

The basis of many important and desirable effects of wine in therapeutics is no longer conjectural.

Results of a series of independently conducted, recent research programs—summarized in the brochure "Uses of Wine in Medical Practice"*—testifies to certain specific physiological properties of wine which now can be utilized to fuller clinical advantage.



*Physiological Properties**
Stimulant to appetite
Gentle, prolonged stimulant to gastric secretion
Relaxant, sedative
Vasodilator, diuretic
Non-ketogenic, euphoretic

*Clinical Applications**
Convalescence, geriatrics
Gastroenterology, urology
Cardiology, neurology
Diabetes
Anorexia, insomnia

*Details of these and other research data as contained in the brochure, "Uses of Wine in Medical Practice," will be sent to you without charge by writing: Wine Advisory Board, 717 Market Street, San Francisco, California.

THERE'S some mighty shrewd wisdom in what Joe says. But human nature being what it is, far too many of us still seek medical advice from those who aren't qualified to give it.

No matter what's bothering you . . . constant fatigue, nerves on edge, recurring aches and pains . . . it is never wise to stay away from your doctor in the hope that you'll run into somebody who will know "just what's best" for your trouble. In fact, it's often dangerous to accept an amateur's "sure cure."

Seek a friend's advice, if you wish, on almost any other problem. But when it comes to your health, and that of your family, by all means don't let anyone other than a physician advise you.

By seeing your doctor at the first sign of trouble, you will not only avoid the hazards of amateur medical advice, but chances are you will save time and money in the long run. In fact, prompt and proper medical care may well turn out to be one of the biggest bargains ever to come your way

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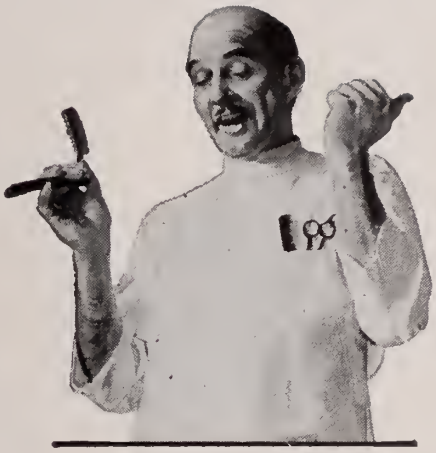
PARKE, DAVIS & COMPANY

MAKERS OF MEDICINES SINCE 1866

Working with your physician, your pharmacist and your hospital to make modern medical care one of the most rewarding investments of your life.



"Joe, the barber" speaks up again . . .

You've met Joe before, doctor—in the 1956 Parke-Davis series of public service messages. And thanks to your warm reception of that advertisement last year . . . so enthusiastically expressed in your letters to us . . . we're featuring "Joe" again—this time in eye-catching color.*

You'll remember Joe's words of wisdom about seeking professional medical advice from the doctor rather than from the "amateur." His remark points up the fact that, by consulting *you* at the first sign of trouble, your patients will save time and money in the long run . . . perhaps even their lives.

Like all ads in the colorful P-D series, we believe this latest message will give your patients and prospective patients a better understanding of the importance of *prompt* and *proper* medical care.

PARKE, DAVIS & COMPANY
Detroit 32, Michigan

* This advertisement appears in the June 17th issue of Life: circulation more than 5½ million; total readership, over 15 million.

NEW...

Each Multiple Compressed Tablet of MEPROLONE provides the inseparable antiarthritic, antirheumatic benefits of:

1. *Prednisolone buffered*—the newest and most potent of the "predni-steroids" for prompt relief of joint pain and arrest of the destructive inflammatory process.

2. *Meprobamate*—the newest and safest of the muscle-relaxant tranquilizers for profound relaxation of skeletal muscle in spasm.

Tolerance to this combination is good because there is little likelihood of sodium retention, potassium depletion or gastric distress with buffered prednisolone, and meprobamate rarely produces significant side effects in therapeutic dosage.

An additional important therapeutic benefit, often overlooked, stems from the tranquilizing action of meprobamate. This component of MEPROLONE relieves mental tension and anxiety so often manifest in arthritics, making them more amenable to other rehabilitation measures.

INDICATIONS: A wide variety of conditions, in which four symptoms predominate: *a*) inflammation *b*) muscle spasm *c*) anxiety and tension *d*) discomfort and disability; i.e., rheumatoid arthritis, rheumatoid spondylitis (Marie-Strümpell disease), Still's disease, psoriatic arthritis, osteoarthritis, bursitis, synovitis, tenosynovitis, myosit i sitis, fibromyositis, neuritis, acute and chronic l pain, acute and chronic primary and secondary f and torticollis, intractable asthma, respiratory a allergic and inflammatory eye and skin disorders (tenance therapy in disseminated lupus erythe periarteritis nodosa, dermatomyositis and sclero

Therapeutic benefits of MEPROLONE compared with traditional an

	relieves pain	suppresses inflam-mation	relaxes muscle	eases anxiety
Salicylates	✓	✓		
Muscle relaxants			✓1	
Tranquilizers				✓1
Steroids	✓	✓		
MEPROLONE	✓	✓	✓	✓

1. Meprobamate is the only tranquilize muscle-relaxant a

SUPPLIED: Multiple Compressed Tablets in b 100 in two formulas as follows: MEPROLONE-1— of prednisolone, 200 mg. of meprobamate and 20 dried aluminum hydroxide gel. MEPROLONE-2— 2.0 mg. of prednisolone in the same formula.

NO OTHER

ANTIRHEUMATIC

PRODUCT

PROVIDES AS MANY

BENEFITS AS

PROLONE*

MEPRO BAMATE
PREDNISO LONE, *buffered*

THE ONLY

ANTIRHEUMATIC,

ANTIARTHRITIC

THAT SIMULTANEOUSLY

RELIEVES:

1. MUSCLE SPASM
2. JOINT INFLAMMATION
3. ANXIETY AND TENSION
4. DISCOMFORT AND DISABILITY

MSD

MERCK SHARP & DOHME
DIVISION OF MERCK & CO., INC. PHILADELPHIA 1, PA.

*MEPROLONE is the trade-mark of Merck & Co., Inc.

PROVEN
PAIN CONTROL
with safety

GRADATIONS OF ANALGESIA

'TABLOID' 'EMPIRIN' COMPOUND®
Acetophenetidin gr. 2½, Acetylsalicylic Acid gr. 3½, Caffeine gr. ½

'TABLOID' 'EMPIRIN' COMPOUND
with CODEINE PHOSPHATE gr. ⅛, No. 1 (N)

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with CODEINE PHOSPHATE gr. ¼, No. 2 (N)

'TABLOID' 'EMPIRIN' COMPOUND
with CODEINE PHOSPHATE gr. ½, No. 3 (N)

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with CODEINE PHOSPHATE gr. 1, No. 4 (N)

(N) subject to Federal Narcotic Law

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N. Y.

Continued from page (1234)

tact Mr. John C. Foster, Executive Secretary, South Dakota Medical Association, 300 First National Bank Bldg., Sioux Falls, S. D.

Dr. Walter E. Murphee of Gainesville has been elected Mayor-Commissioner of that city.

Dr. Curtis W. Bowman of St. Petersburg has been elected vice president of the Southeastern Surgical Congress. Dr. Howard Mahorner of New Orleans is president succeeding Dr. J. O. Morgan of Gadsden, Ala.

Dr. Joseph B. Ganey of Bradenton has been named "Outstanding Young Man of the Year" by the Bradenton Junior Chamber of Commerce.

"Sword and Scalpel" is the title of Dr. Frank G. Slaughter's new book just published by Doubleday & Co. A resident of Jacksonville, Dr. Slaughter in the book tells the story of an Army surgeon who is captured by the Red Chinese in North Korea, along with his commanding officer, a priest and others. Reviewers have praised the book as one of Dr. Slaughters' best ones.

Dr. Hyman J. Roberts of West Palm Beach was one of the guest lecturers for the Florida Trudeau Society at its recent annual conference in Orlando. The title of his presentation was "An Analysis of Important Cardiovascular and Pulmonary Complications Following General and Thoracic Surgery."

Dr. Hawley H. Seiler of Tampa participated recently in the scientific program of the Second Inter-American Medical Convention held in the El Panama Hotel at Panama City, R. P. The title of his address was "Surgery of Pulmonary Lesions Other than Cancer." He also presented a paper "The Surgery of Pulmonary Tuberculosis" at the annual meeting of the Panama Chapter of the American College of Chest Physicians.

Drs. Eugene L. Jewett and Freeman D. Stanford of Orlando presented a paper on "An Evaluation of a New Hip Prosthesis Used in Sixty Patients and Sixty-Two Hips over a Period of Six Years" at the recent Southeastern Surgical Congress held at St. Petersburg.

Dr. William J. Creel of Eau Gallie has been awarded a plaque by Kiwanis International ac-

cording distinctive recognition and gratitude, and a 25 year pin for his perfect attendance at club meetings.

Drs. Peter B. Wright and Louis P. Brady of Orlando attended the recent meeting of the Association of Bone and Joint Surgeons held at Havana, Cuba, and presented a paper on "Anatomic Considerations in Whiplash Injuries of the Neck."

A new 16 mm. color motion picture on the use of steroids in the treatment of rheumatoid arthritis has been released for showing to professional groups by the Schering Corp. The 25 minute film, the fourth in Schering's series on hormone therapy and the endocrines, was produced by the company's Clinical Research Division and Biochemical Research Department. It is available to medical groups without charge upon request to The Audio-Visual Department, Schering Corp., Bloomfield, N. J.

Dr. J. Brown Farrior of Tampa was guest lecturer at the recent annual meeting of the Georgia Society of Ophthalmology and Otolaryngology held at Savannah. He discussed diseases and surgery of the ear.

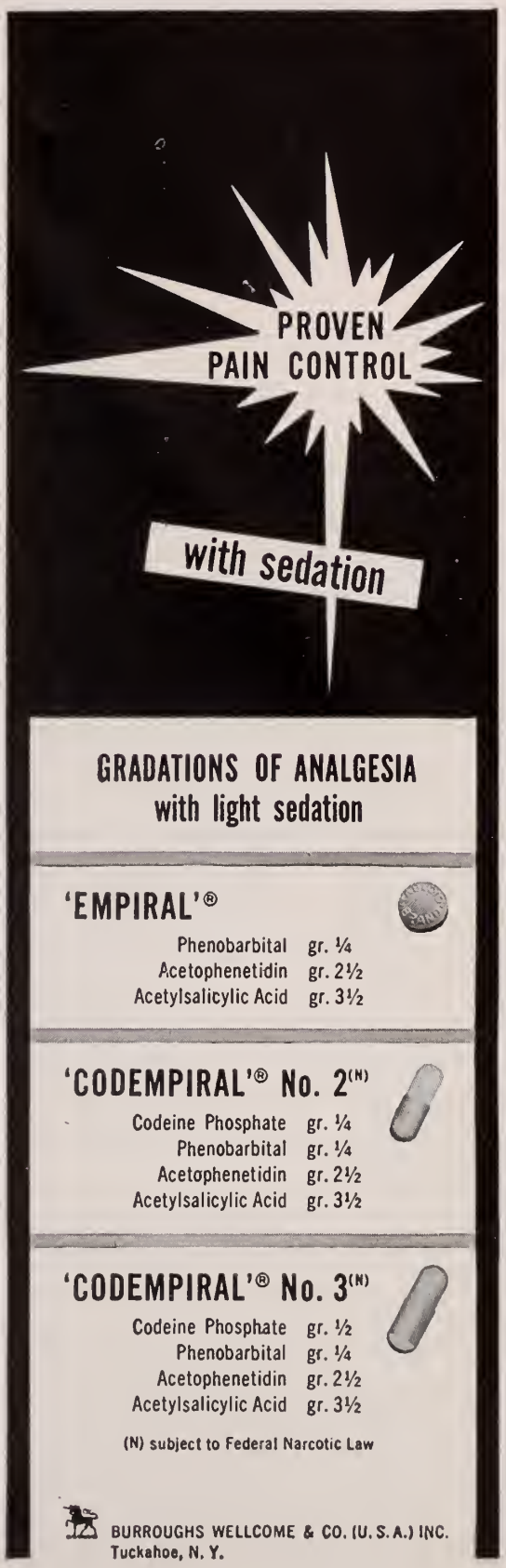
Dr. Eugene R. Speirs of Kissimmee has returned from St. Louis where he attended the Ninth Annual American Academy of General Practice Scientific Assembly.

Drs. Samuel G. Hollingsworth and Chas. W. Larrabee of Bradenton and Dr. J. O. Brown of Palmetto were honored recently by the Manatee County Medical Society with a "Doctors Day" commemorative banquet.

Dr. Sidney G. Kennedy Jr. of Pensacola has been elected president of the Rotary Club of that city to take office on July 1.

Dr. Douglas R. Murphy of Venice has been elected president of the Venice-Nokomis Rotary Club.

Dr. Howard M. DuBose of Lakeland has been elected president of the Florida Trudeau Society to succeed Dr. Simon D. Doff of Jacksonville. Dr. Kip G. Kelso of Vero Beach is vice president, and Dr. Frank Cline Jr. of Tampa is secretary.



Steroid-Nutritional Therapy Is Constructive Approach for the First Signs of Aging

Emphasis on Early Treatment Before "Damage" Is Done

The first subtle suggestions of physiologic deterioration should not be dismissed if serious somatic and metabolic disorders are to be avoided. Prompt institution of steroid-nutritional therapy may forestall and even reverse premature "damage" and help prolong the active life of the patient.

Some of the most common symptoms of declining gonadal function and nutritional insufficiency are vague pains in the bones and joints, easy fatigability, decreased muscular tone, loss of appetite, chronic mental fatigue and general malaise. In older patients, these complaints are frequently indicative of degenerative processes when they cannot be attributed to a specific cause.

The comprehensive formula of "Mediatric" is specifically designed to provide three therapeutic services: 1. *protect* general metabolic integrity; 2. *preserve* physiologic efficiency; 3. *prevent* premature damage.

"Mediatric" supplies estrogen and androgen in small amounts to exert a favorable influence on bone and protein metabolism,[1] restore muscle tone and coordination,[2] and increase the tensile strength of the skin.[3] The two steroids appear to have an additive metabolic effect, while their opposing action on sex-linked tissue minimizes the incidence of untoward reactions.

Dietary supplements, including essential B vitamins and ascorbic acid, ensure adequate nutrition, prevent moderate anemias, and maintain efficient enzyme systems. The mood elevating effect of a mild antidepressant helps restore emotional stability and increases mental alertness.

Recommended dosages: Male—1 tablet or 1 capsule (or 3 teaspoonfuls) daily, or as required. Female—1 tablet or 1 capsule (or 3 teaspoonfuls) daily, or as required, taken in 21 day courses with a rest period of one week between courses.

Bibliography on request.

"Mediatric"® Tablets and Capsules

Each capsule or tablet contains:

Conjugated estrogens equine ("Premarin"®)	0.25 mg.
Methyltestosterone	2.5 mg.
Vitamin C (ascorbic acid)	50.0 mg.
Thiamine mononitrate (B_1)	5.0 mg.
Vitamin B_{12} with intrinsic factor concentrate	1/6 U.S.P. Unit
Folic acid U.S.P.	0.33 mg.
Ferrous sulfate exsic.	60.0 mg.
Brewers' yeast (specially processed)	200.0 mg.
d-Desoxyephedrine HCl	1.0 mg.

Tablets—No. 752—bottles of 100 and 1,000.
Capsules—No. 252—bottles of 30, 100, and 1,000.

"Mediatric" Liquid

Each 15 cc. (3 teaspoonfuls) contains:

Conjugated estrogens equine ("Premarin"®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl (B_1)	5.0 mg.
Vitamin B_{12}	1.5 mcg.
Folic acid U.S.P.	0.33 mg.
d-Desoxyephedrine HCl	1.0 mg.

Contains 15% alcohol

No. 910—bottles of 16 fluidounces and 1 gallon.

Ayerst Laboratories
New York, N. Y. • Montreal, Canada

5711

"MEDIATRIC" *will promote better health and vigor when the patient complains of . . . easy fatigability . . . vague pains in the bones and joints*

These symptoms may be the first signs of degenerative changes in patients over 40. "Mediatric" supplies small doses of estrogen and androgen, important dietary supplements and a mild antidepressant to forestall or even correct the "damage" of premature aging.

"Mediatric"® – steroid-nutritional compound, available in tablets, capsules and liquid.

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PREVENT P.P.B.E.

Postpartum breast engorgement was satisfactorily prevented in 96 per cent of a series of 267 patients who received "Premarin" with Methyltestosterone promptly after delivery. No serious side effects were noted, and the absence of mental depression in the puerperium was notable. (Fiskio, P.W.: GP 11:70 (May) 1955.)

"PREMARIN"® WITH METHYLTESTOSTERONE
for combined estrogen-androgen therapy

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Ayerst Laboratories • New York, N. Y. • Montreal, Canada

5737

Dr. DeWitt C. Daughtry of Miami has been chosen president of the Florida Tuberculosis and Health Association.

Dr. Sherman B. Forbes of Tampa attended the Sixteenth Clinical Meeting of the Wilmer Residents Association held at the Wilmer Opthalmological Institute of The Johns Hopkins Hospital and University in Baltimore, April 3-5.

Dr. Frank M. Woods of Miami was installed as treasurer and Dr. James L. Campbell Jr. of Orlando as secretary of the Southeastern Section of the American Urological Association at the group's 21st annual meeting held at Atlanta.

Dr. Roy E. Campbell of St. Augustine attended a recent four day course on trauma sponsored by the American College of Surgeons in Chicago.

Dr. William J. Knauer Jr. of Jacksonville attended the Sixteenth Clinical Meeting of the Wilmer Residents Association held early in April at the Wilmer Ophthalmological Institute of The Johns Hopkins Hospital and University in Baltimore.

COMPONENT SOCIETY NOTES

Brevard

The April meeting of the Brevard County Medical Society was held in Melbourne at the First Methodist Church. Among the guests for the meeting were ministers serving churches in the county.

Dr. Lorant Forizs, of Avon Park, Chief Psychiatrist at the Alcoholic Rehabilitation Center, was principal speaker. He was introduced by Dr. Jack T. Bechtel, program chairman.

The March meeting of the Society was held at the Rockledge Country Club. Dr. Ben J. Sheppard, of Coral Gables was principal speaker.

Collier

Dr. Carey N. Barry, of Fort Myers, was principal speaker for the April meeting of the Collier County Medical Society held at the Elks Club in Naples.

Leon-Gadsden-Liberty-Wakulla-Jefferson

Dr. Joseph Allen Hertell, of Atlanta, Director of the Blood Bank Program for the American Red Cross, addressed the quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson

(Continued on page 1248)

Anderson Surgical Supply Co.

Established 1916

A GOOD REPUTATION

It takes years to build, but can be quickly destroyed.
It must be carefully guarded.
"A good name is rather to be chosen than great riches."

MEMBER

Distributors of Known Brands of Proven Quality

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SAFETY FIRST

AFTER ALMOST FIVE YEARS OF INVESTIGATION AND EXTENSIVE CLINICAL USE (MILLIONS OF PRESCRIPTIONS) THERE HAS NOT BEEN A SINGLE REPORT OF A SERIOUS OR FATAL REACTION TO ERYTHROCIN

This remarkable safety record stands unparalleled in systemic antibiotic therapy today. In addition to being an unusually well-tolerated drug . . . ERYTHROCIN (compared to most other commonly-used antibiotics) is virtually free of side effects.

Still, with this virtual freedom from toxicity, ERYTHROCIN is effective in the great majority of common, bacterial respiratory infections. In speaking of pneumonia, Herrell said, *"the lack of toxic manifestations following administration of erythromycin today actually favors its use over that of the broad-spectrum antibiotics in the treatment of this infection."*[1]

While discussing purulent cellulitis and sepsis due to staphylococci, Eastman, et al., mentioned erythromycin as a *drug of first choice in treating these conditions.*[2]

Meanwhile, Solomon and Johnston stated, *"in the staphylococcic and streptococcic infections, other than pneumonias, without exception the results of treatment with erythromycin were excellent."*[3]

IN ANTIBIOTIC THERAPY

You, too, can have these same good results in your everyday practice—plus the assurance of prescribing a drug proved to be exceptionally well-tolerated in almost five years' use. *Filmtab* ERYTHROCIN Stearate (100 and 250 mg.), in bottles of 25 and 100.

FILMTAB®

Erythrocin®

STEARATE (Erythromycin Stearate, Abbott)

1. Herrell, W. E., Erythromycin, Antibiotics Monographs, No. 1, p. 34, New York, Medical Encyclopedia Inc., 1955. 2. Eastman, G., Cook, E. and Bunn, P., N. Y. State J. Med., 56:241, 1956. 3. Solomon, S. and Johnston, B., Amer. J. Med. Sc., 230:660, 1955.

Abbott

Film-sealed tablets, Abbott; pat. applied for.

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pull yourself together Doc...

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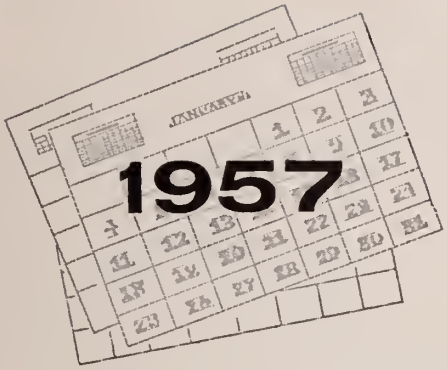

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initial tetracycline blood levels

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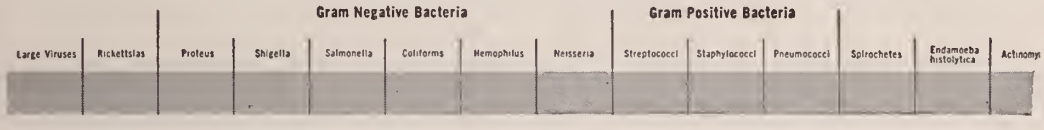
Squibb Tetracycline Phosphate Complex

the broad **clinical** spectrum of SUMYCIN against pathogenic organisms



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the new **phosphate complex** of tetracycline

SUMYCIN
a **single** antibacterial antibiotic

SUMYCIN
a **well tolerated** antibiotic

SUMYCIN
a **true** broad spectrum antibiotic

Minimum adult dose: 1 capsule q.i.d.
Each Sumycin capsule contains the equivalent
of 250 mg. tetracycline hydrochloride.
Bottles of 16 and 100.

SQUIBB *Squibb Quality—the Priceless Ingredient*

'SUMYCIN' IS A SQUIBB TRADEMARK

(Continued from page 1243)

County Medical Society held the middle of April in the W. T. Edwards Hospital at Tallahassee. Dr. Hertell discussed "The Role of the Physician in Disaster Planning."

Manatee

The Manatee County Medical Society had as guests for its April meeting the members of the Manatee County Bar Association. The meeting was held in the Manatee River Hotel at Bradenton.

The program consisted of a social hour and dinner, and a showing of the film "The Medical Witness." Following review of the film, there was a question and answer period with an attorney and a physician serving as panel members.

BIRTHS AND DEATHS

Births

Dr. and Mrs. Robert E. Raborn, of Delray Beach, announce the birth of a son, Douglas Kent, on February 18, 1957.

Deaths—Members

Beckman, George E., Jacksonville ... March 27, 1957
Heath, Guy Wilkerson, West Palm Beach ... Feb. 3, 1957
Larrabee, Chas. W., Bradenton ... April 14, 1957
Palmer, Harrison G., St. Petersburg ... February 9, 1957
Schirmer, Adelbert F., Orlando ... April 4, 1957
Smith, James A., Sanford ... February 19, 1957
Wilkinson, Benjamin A., Tallahassee ... April 12, 1957

Deaths—Other Doctors

Campbell, William Breaden, Orlando ... December 28, 1956
Johnson, William A., Iowa Falls, Iowa ... October 3, 1956
Stockwell, William Morgan, Dunedin ... January 3, 1957
Young, Robert U., Tampa ... April 11, 1957
Blum, Leo J. Jr., Warner Robins, Ga. ... December 8, 1956
Durlacher, Stanley H., Coral Gables ... March 19, 1957

NEW MEMBERS

The following doctors have joined the State Association through their respective county medical societies.

Aldrich, Ellerton G., Sarasota
Allee, James W., Treasure Island
Allen, Marvin S., Hollywood
Bean, Lewis A., Cocoa Beach
Beyer, Damon P., Pompano Beach
Cooper, Henry R., Fort Lauderdale
Evans, Warren C., Sarasota
Flatt, Richard S., Sarasota
Fulenwider, Robert G., Fort Lauderdale
Glenn, Leland K., Fort Myers
Harrell, George N. Jr., Palmetto
Isaacson, Sherwin, Lake Worth
Jenkins, William J., Sarasota

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MILLIONS OF ASTHMATIC ATTACKS

have been aborted faster...more effectively... more economically with

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SIMPLE TO USE

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SUITABLE FOR CHILDREN, TOO

SLIPS INTO POCKET OR PURSE

Automatically measured dosage and true nebulization...nothing to pour or measure...One inhalation usually gives prompt relief of acute or recurring asthmatic attacks.

Medihaler-Epi replaces injected epinephrine in urticaria, edema of glottis, etc. due to acute food, drug or pollen reactions...Each 10 cc. bottle delivers 200 inhalations.

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Medihaler-EPI® Riker brand epinephrine U.S.P. 0.5% solution in inert, nontoxic aerosol vehicle. Each measured dose 0.12 mg. epinephrine. In 10 cc. bottle with measured-dose valve.

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Note: First prescription for Medihaler medications should include the desired medication and Medihaler Oral Adapter (supplied with pocket-sized plastic carrying case for medication and Adapter).

The Medihaler Principle

is also available in Medihaler-Nitro™ (octyl nitrite) for the rapid relief of angina pectoris ...and Medihaler-Phen™ (phenylephrine-hydrocortisone-neomycin) for lasting, effective relief of nasal congestion.

Riker LOS ANGELES

Konstantinu, Ilias, Englewood
Lewis, George N., Tallahassee
Lewis, Richard S., Pompano Beach
Lowery, Daniel B., Clearwater
McGehee, Nat T. Jr., Hollywood
Parker, Vann, Sanford
Rigby, William O., Clewiston
Senese, John G., St. Petersburg
Smith, Ballard F., Fort Lauderdale
Walker, Bruce E., St. Petersburg
Ward, John A., Monticello
Wiley, Thomas M. Jr., Ft. Myers
Wilson, Theodore W., Sarasota
Abele, Virgil, Madison
Avant, Earl S., Orlando
Axler, Morton M., Coral Gables
Bascove, Selig J., Hollywood
Beamer, William D., St. Cloud
Blum, Otto S., Miami Beach
Boardman, Willard H., Orlando
Carson, Doris N., Jacksonville
Chittenden, George E., Winter Park
Covalt, Nila K., Winter Park
Cowdery, Patricia C., Jacksonville
Dabby, Victor, Coral Gables
Daniels, Richard E., Pensacola
Davis, Donald J., Orlando
Ferguson, James H., Miami

Forizs, Lorant, Avon Park
Frame, Eugene M., Jacksonville
Freedland, Marvin S., Miami
Griffith, Henry W., S. Miami
Gutman, Paul E., Pompano Beach
Henderson, Claude B., Jacksonville
Hunter, Caroline B., Coral Gables
Hyde, Albert M., Lakeland
Jensen, Marshall N., Winter Park
McCallister, Louis R., Miami
Machle, Willard Sr., Boca Raton
Marks, Charles H., Ocala
Meadows, Frederick C., Coral Gables
Meleney, Frank L., Miami
Millman, Bernard M., Pompano Beach
Mills, Bruce E., Okeechobee
Mori, Paul A., Jacksonville
Morris, Jim, Titusville
Nass, William H., Pensacola
Neal, John B., Jacksonville
Parvey, Arthur I., Jacksonville
Rester, James H. Jr., Lake Worth
Segrest, Ralph H., Bonifay
Smaller, Ben I., DeLand
Spoto, Peter J., Tarpon Springs
Stratton, Hershel R., Sarasota
Sullivan, James J., Lake City
Terheyden, Wm. A. Jr., Miami
Turner, Wilbur S., Ft. Pierce
Weinstein, Pierce, West Palm Beach
Wilson, Leo H. Jr., Miami

OBITUARIES

Russell Spaldon Underwood

Dr. Russell Spaldon Underwood of Miami died of uremia following chronic nephritis at Jackson Memorial Hospital on Nov. 3, 1956. He was 30 years of age.

A native of Waynesville, N. C., Dr. Underwood received his academic education at Notre Dame University and his medical training at Duke University School of Medicine. He was awarded his degree in medicine by the latter institution in 1951. Thereafter, he served as medical intern and assistant pediatric resident at St. Louis City Hospital in St. Louis, Mo., and then as resident in pediatrics at Jackson Memorial Hospital in Miami.

Deciding to locate in Miami, Dr. Underwood became associated in the private practice of pediatrics in Miami and South Miami with Dr. Robert F. Mikell. Locally, he served on the at-

(Continued on page 1256)

relaxes both mind and muscle

for anxiety and tension in everyday practice

- well suited for prolonged therapy
- well tolerated, relatively nontoxic
- no blood dyscrasias, liver toxicity, Parkinson-like syndrome or nasal stuffiness
- chemically unrelated to phenothiazine compounds and rauwolfia derivatives
- orally effective within 30 minutes for a period of 6 hours

For treatment of **anxiety and tension states and muscle spasm**

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THE ORIGINAL MEPROBAMATE

2-methyl-2-n-propyl-1,3-propanediol dicarbamate—U. S. Patent 2,724,720

NOW IN 2 CONVENIENT DOSAGES

Tranquilizer with muscle-relaxant action

DISCOVERED AND INTRODUCED

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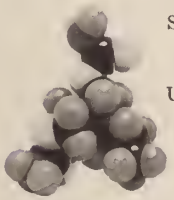
SUPPLIED: *(Bottles 50 tablets)*
400 mg. scored tablets
200 mg. sugar-coated tablets

USUAL DOSAGE: *One or two 400 mg. tablets t.i.d.*

Literature and Samples Available on Request



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NEW 200 mg. SUGAR-COATED TABLETS

STANDARD 400 mg. SCORED TABLETS

Relaxes without impairing mental or physical efficiency

. . . well suited for prolonged therapy

1 "The primary finding of these studies is that meprobamate ['Miltown'] alone . . . produces no behavioral toxicity in our subjects as measured by our tests of driving, steadiness and vision."

Marquis, D. G., Kelly, E. L., Miller, J. G., Gerard, R. W. and Rapoport, A.: Ann. New York Acad. Sc. 67:701, May 6, 1957.

2 "Since it [meprobamate—'Miltown'] does not cloud consciousness or lessen intellectual capacity, it can be used . . . even by those busily occupied in intellectual work."

Keyes, B. L.: Pennsylvania M. J. 60:177, Feb. 1957.

3 ". . . the patient never describes himself as feeling detached or 'insulated' by the drug ['Miltown']. He remains completely in control of his faculties, both mental and physical . . ."

Sokoloff, O. J.: A.M.A. Arch. Dermat. & Syph. 74:393, Oct. 1956.

4 "It ['Miltown'] . . . does not cloud the sensorium, and has a helpful somnifacient effect devoid of 'hangover'."

Kessler, L. N. and Barnard, R. D.: M. Times 84:431, April 1956.

5 "In anxiety and tension states, meprobamate relaxes without dulling cortical function to the same extent as the commonly-used barbiturates."

Rindskopf, W., Ravreby, M., Gutenkauf, C. and Sands, S. L.: J. Iowa M. Soc. 47:57, Feb. 1957.

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DISCOVERED AND INTRODUCED BY WALLACE LABORATORIES

Miltown®

2-methyl-2-n-propyl-1, 3-propanediol dicarbamate—U.S. Patent 2,724,720

TRANQUILIZER WITH MUSCLE-RELAXANT ACTION

SUPPLIED: *400 mg. scored tablets*
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USUAL DOSAGE: *One or two 400 mg. tablets t.i.d.*

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now *". . . care of the man rather than merely his stomach."*

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Miltown® + *anticholinergic*

controls gastrointestinal dysfunction

because it **cares for the man**

At the cerebral level

the tranquilizer *Miltown* in "Mil*path*" controls the psychogenic element in G. I. disturbances. (Miltown does not produce barbiturate loginess or hangover.)

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the anticholinergic, *tridihexethyl iodide*, in "Mil*path*" blocks vagal impulses to prevent hypermotility and hypersecretion.

for duodenal ulcer • gastric ulcer • intestinal colic
spastic and irritable colon • ileitis • esophageal spasm
G.I. symptoms of anxiety states

prescribe:
1 tablet t.i.d. at mealtime and 2 at bedtime.

"Milpath"

Miltown® + *anticholinergic*

Formula:

Miltown® (meprobamate) 400 mg. (2-methyl-2-*n*-propyl-1, 3-propanediol dicarbamate)
U. S. Patent 2,724,720

tridihexethyl iodide 25 mg. (3-diethylamino-1-cyclohexyl-1-phenyl-1-propanol-ethiodide)
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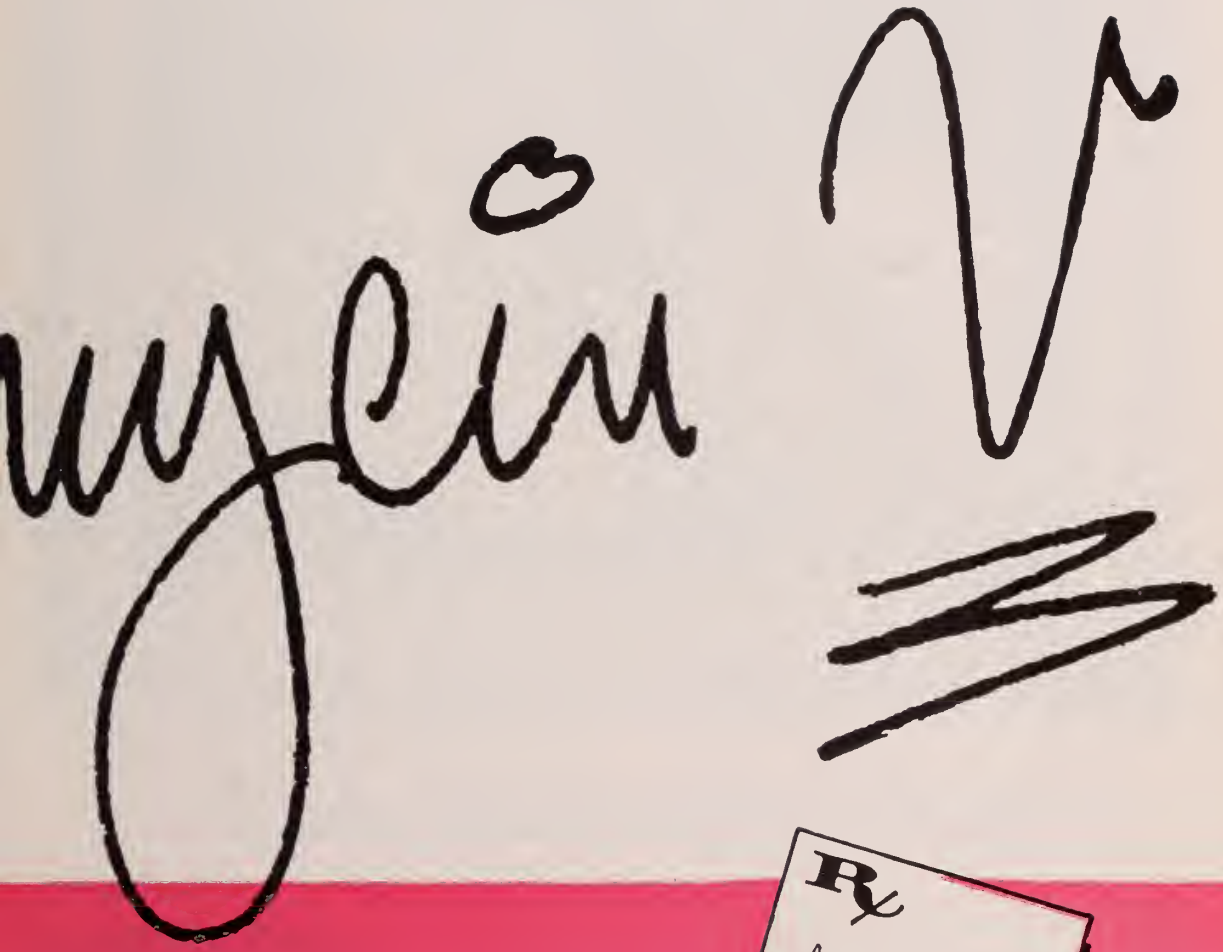

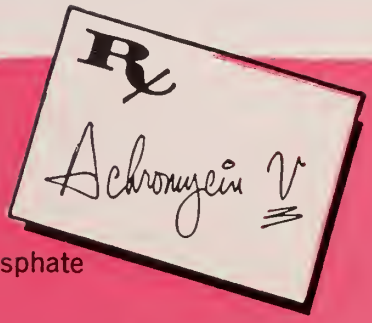

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ACHROMYCIN* V Tetracycline Buffered with Phosphate

CAPSULES—Each capsule (pink) contains tetracycline equivalent to 250 mg. of tetracycline HCl, phosphate-buffered. Bottles of 16 and 100 capsules.

SYRUP—Each teaspoonful (5 cc.) of orange-flavored syrup contains 125 mg. of tetracycline HCl activity, phosphate-buffered. Bottles of 2 and 16 fl. oz.

ACHROMYCIN V dosage: 6-7 mg. per lb. of body weight per day for children and adults.

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unique derivative of *Rauwolfia canescens*

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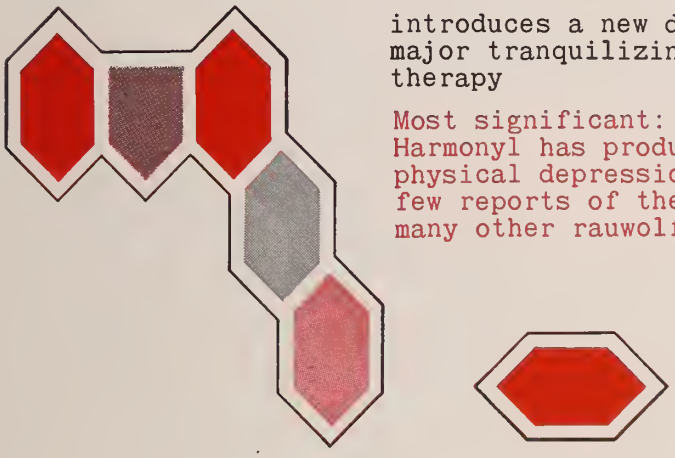
(Deserpidine, Abbott)



introduces a new degree of safety in major tranquilizing—antihypertensive therapy

Most significant: In extensive trials, Harmonyl has produced less mental and physical depression. And there are very few reports of the lethargy seen with many other rauwolfia preparations.

More than two years of clinical evaluation have proven Harmonyl a notably safe and effective agent in cases ranging from mild anxiety to major mental illnesses and in hypertension. Harmonyl exhibited significantly fewer and milder side effects in comparative studies with reserpine—while demonstrating effectiveness comparable to the most potent forms of rauwolfia.

Safety—plus marked clinical effectiveness

Harmonyl proved particularly effective, for example, in tranquilizing a group of 40 chronically ill, agitated senile patients.[1]

Of particular interest is the observation that patients became more lucid and alert on Harmonyl therapy. And there was a complete absence of side effects with Harmonyl—although a similar group on reserpine developed such side effects as anorexia, headache, bizarre dreams, shakes, nausea and vomiting.

Following another eight-month study of chronic, hospitalized mental patients, Ferguson[2] stated:

- Harmonyl benefited at least 15% more overactive patients and proved more potent in controlling aggression—requiring only one-half to two-thirds the dosage of reserpine.
- Patients experiencing side reactions on reserpine often were completely relieved when changed to Harmonyl.

Ferguson concluded: "*The most notable impressions were the absence of side effects and relatively rapid onset of action with Harmonyl.*"

Comparative studies have shown Harmonyl and reserpine about equal in hypotensive effect. The tranquilizing action of the two drugs also appeared similar—except that few cases of giddiness, vertigo, sense of detached existence or disturbed sleep were seen with Harmonyl.

Professional literature is available upon request. Harmonyl is supplied in 0.1-mg., 0.25-mg., and 1-mg. tablets.

Abbott

References: 1. Communication to Abbott Laboratories, 1956. 2. Ferguson, J. T.: Comparison of Reserpine and Harmonyl in Psychiatric Patients: A Preliminary Report, Journal Lancet, 76:389, December, 1956. *Trademark

706185

(Continued from page 1250)

tending staffs of Jackson Memorial Hospital and Variety Children's Hospital and also on the clinical faculty of the University of Miami School of Medicine.

Dr. Underwood was a member of the Dade County Medical Association, the Florida Medical Association and the American Medical Association. He also was affiliated with various groups of his specialty.

Surviving are the widow, Jean Bennett Underwood, and one daughter, Carol, of Miami; the parents, Mr. and Mrs. William S. Underwood, of Waynesville; and two brothers, Philip Underwood, of Waynesville, and Richard Underwood, of Asheville, N. C.

Carl A. Williams

Dr. Carl A. Williams of St. Petersburg died on Dec. 24, 1956, in New London, Conn., after a long illness. He was 84 years of age.

Dr. Williams was a native of Mystic, Conn., where he was born in 1872. He was a graduate of the Bucklyn Institute in Mystic and of New York University. He received his medical degree from the Hahnemann Medical College and Hospital of Philadelphia in 1895 and did postgraduate work at Harvard Medical School.

After practicing as an internist for 20 years in New London and in Worcester, Mass., Dr. Williams established a practice in St. Petersburg. He then pursued further studies in medicine abroad, visiting clinics in France, Germany, Austria and England and studying at the Sorbonne in Paris and the University of Zurich. He continued to practice internal medicine, and cardiology in particular, in St. Petersburg for 40 years, maintaining a home there and also one in Groton, Conn. He belonged to the Masonic order and was a member of the Baptist Church of Mystic.

Dr. Williams received his license to practice medicine in Florida in 1909. Several years later, soon after he engaged in active practice in St. Petersburg, he became a member of the Pinellas County Medical Society. For 31 years he had held membership in the Florida Medical Association, and he also was a member of the American Medical Association.

He is survived by his widow, Mrs. Nelle Ketner Williams, and a daughter, Edith B. Williams, both of St. Petersburg.

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CLAFANONE is a new, propiophenone compound with marked activity against intestinal coliform organisms and virtually no toxicity or side effects because—being insoluble—its activity is confined to the intestine.

CLAFANONE promptly controls simple diarrheas such as "vacation diarrhea," diarrhea due to dietary indiscretion, and other diarrheas without culturable pathogens. In infectious diarrheas, Clafanone is a useful adjunct to antibacterial and supportive therapy.

Especially acceptable to children as a pleasantly flavored oral suspension. Effective in patients of all ages as a suspension or in tablets.

CLAFANONE™—*brand of alkofanone*

ROCHE *Original Research in Medicine and Chemistry*

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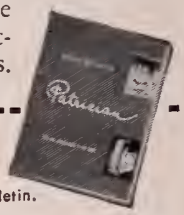

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for relief that lasts—longer

in *TENOSYNOVITIS*—
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for surgery

Osteoarthritis
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Bursitis
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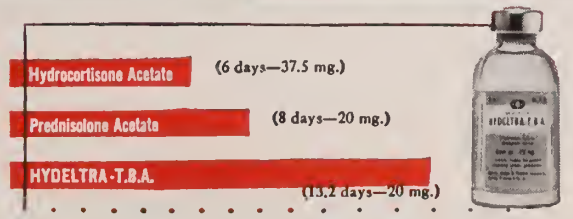
Trigger finger
Tenosynovitis
Trigger points
Tennis elbow
Lumbosacral strain
Capsulitis
Frozen shoulder
Coccydynia
Rheumatoid nodules
Fibrositis
Tensor fascia lata syndrome
Collateral ligament strains
Sprains
Radiculitis
Osteochondritis
Ganglia

Anti-inflammatory effect lasts longer than that provided by any other steroid ester



Dosage: the usual intra-articular, intra-bursal or soft tissue dose ranges from 20 to 30 mg. depending on location and extent of pathology.

Supplied: Suspension 'HYDELTRA'-T.B.A.—20 mg./cc. of prednisolone *tertiary*-butylacetate, in 5-cc. vials.

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BOOKS RECEIVED

The Principles and Art of Plastic Surgery. By Sir Harold Gillies, C.B.E., F.R.C.S., and D. Ralph Millard, Jr., M.D. Two volumes boxed. Pp. 652. Illus. 2,472 with 122 in color. Price, $35.00. Boston, Little, Brown & Company, 1957.

This unique work presents scientific fact and daring innovation most engagingly combined with a highly readable, entertaining and anecdotal style of writing. It is not only a textbook of plastic surgery but also the autobiography of a world-famous surgeon. "This is a Plastic Play," writes the junior author in the Preface, "which has been re-enacted as it actually happened, using the original cast as actors. Its setting is not confined to the clinic and the operating room, but ventures onto the golf course, into the lecture hall and along the fishing stream. It has been four years in the making and covers a span of forty surgical years . . . The theme throughout is the perpetual Battle of Beauty versus Blood Supply. Each character, whether he dominates an entire scene or has but a fleeting moment on the stage, will be seen to take part in this conflict. Herein lies the drama!"

The name of Sir Harold Gillies is synonymous with the development of plastic surgery. In both world wars and in civilian practice in London, he has exercised his unique talents in restoring disfigured parts to normalcy. The co-author, Dr. D. Ralph Millard Jr. of Miami, was Chief Plastic Surgeon to the Marines in Korea. A Diplomate of the American Board of Plastic Surgery, he has now established his practice in Miami and is also teaching at the University of Miami School of Medicine.

The book is copiously illustrated, and page layouts are so arranged that the appropriate illustrations are immediately adjacent to the text. Drawings often supplement photographs. The scope and worth of these two unusual volumes are aptly described in the Foreword by Dr. Jerome Pierce Webster, Professor of Clinical Surgery, College of Physicians and Surgeons, Columbia University:

"A plastic surgeon reading this fascinatingly vivid work feels himself in the presence of a master, sitting at his side, and almost hearing his voice review the stories, clinical and personal, of myriads of patients. All that goes into making the surgeon's profession a book of life is here in abundance: a compilation of hundreds of cases gathered over the years, with their thousands of hours of patient work at the operating table, on the wards, and in the consulting room, and with their human touches of drama, both comedy and tragedy. Technics are described, results of a wide gamut of procedures are shown, the pros and cons of controversial points are debated, but above all this work has color, life and freshness. Pedantry is absent, and creative teaching stimulates the reader to new and wider vistas.

"The interest of this book to plastic surgeons is three-fold. It is a textbook of plastic surgery unique in its humanness; it covers to a large extent the development of plastic surgery during the twentieth century, when the greatest advances in this specialty have been made and the largest number of patients have been restored; and it is an autobiography of the outstanding plastic surgeon of the century, whose influence has been felt throughout the world and will continue to be felt for years to come. These are volumes which every man who attempts to do plastic surgery should own."

New and Nonofficial Remedies 1957. Council on Pharmacy and Chemistry of the American Medical Association. Pp. 584. Price, $3.35. Philadelphia, J. B. Lippincott Company, 1957.

This annual publication of the Council on Pharmacy and Chemistry of the American Medical Association contains descriptions of drugs evaluated on the basis of available scientific data and reports of investigations. It deals with agents proposed for medicinal or adjunctive use in or on the human body for the diagnosis, prevention

(Continued on page 1268)

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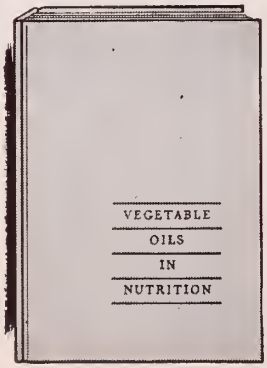

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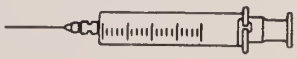

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1. Levy, S., *JAMA.*, 153:1260, 1953
2. Thompson, L., Procter R., *North Carolina M. J.*, 15:596, 1954

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(Continued from page 1260)

or treatment of disease. Since the initiation in 1955 of the revised program of operation for evaluation of drugs, the scope of the book no longer is restricted only to descriptions of drugs having established uses but has been expanded to provide for the inclusion of information on all available new drugs. Dosage forms and sizes, the names of manufacturers, and monographs describing ready-prepared mixtures of two or more drugs have been eliminated to permit more emphasis on basic information. When considered necessary, simultaneous or combined use of two or more drugs is discussed in monographs on the individual drugs or in general statements on classes of drugs to which they belong.

It is noteworthy that New and Nonofficial Remedies, which has appeared in annual book form since 1907 and for many years as a regular cumulative feature of the Council's column in the Journal of the American Medical Association, appears in this 1957 edition for the last time under the familiar title. It has been retitled New and Nonofficial Drugs, and the Council has been renamed the Council on Drugs. The 1958 and subsequent editions of the book will carry the revised title.

Home Health Emergencies. Medical Department, The Equitable Life Assurance Society of the United States. Pp. 256. On request.

This 256 page illustrated pocket size volume, published by the Medical Department of the Equitable Life Assurance Society is a new "common sense" kind of home nursing and first aid guide for family use, stressing prevention of accidents and illness. Developed from original manuscript by Granville W. Larimore, M.D., it is available on individual request without charge or obligation from the Equitable's Bureau of Public Health at 393 Seventh Avenue, New York 1, N. Y. The purpose of the book is to help people assume a share of responsibility for personal and family health as a step toward "assurance of a fuller life." Emphasis is given to the home nurse's relationship with physicians and other members of the health professions, to the value of first aid and home nursing courses, to the need for professional guidance in complicated cases, and to the importance of considering the patient's emotional as well as physical needs. The first aid section, consisting of more than 200 pages, gives special emphasis to health problems and emergencies encountered in the family and at home, from "abdominal pain" to "zoonoses" (nine of them, from cat-scratch disease to trichinosis).

The Medical Department has also issued a leaflet based on the book which gives basic first aid rules in brief. Titled "First Aid — if you had to act now, would you know what to do?", the leaflet has space for notation of the telephone number of the family physician, ambulance service, hospital, police station and fire department. It also has a coupon for use in requesting a family copy of "Home Health Emergencies." It is available in bulk for distribution by private practitioners, medical institutions, health organizations and agencies.

OTHER BOOKS RECEIVED:

Expectant Motherhood. By Nicholson J. Eastman, M.D., Boston, Little Brown & Company.

Drugs in Current Use 1957. Edited by Walter Modell, M.D., New York, Springer Publishing Company, Inc.

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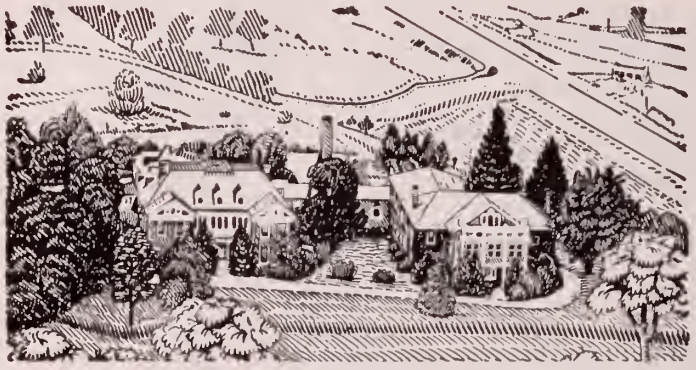

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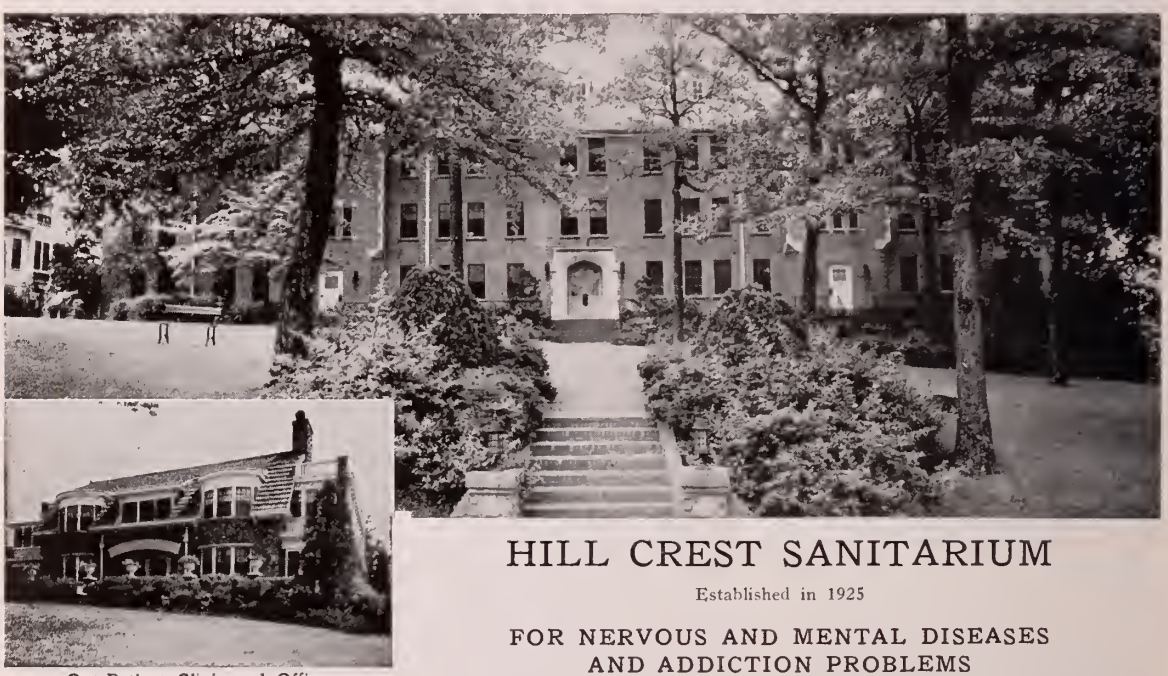

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B-Northeast	Leo M. Wachtel, Jacksonville	Don C. Robertson, Orlando	Orlando, Oct. 30, '57
C-Southwest	Gordon H. McSwain, Arcadia	John M. Butcher, Sarasota	Clearwater, Oct. 29, '57
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Allergy Society	Norris M. Beasley, Ft. Lauderdale	I. Irving Weintraub, Gainesville	
Anesthesiologists, Soc. of	Stanley H. Axelrod, Miami Beach	George C. Austin, Miami	
Chest Phys., Am. Coll., Fla. Chap.	Clarence M. Sharp, Jacksonville	Ivan C. Schmidt, W. Palm Beach	
Derm. and Syph., Assn of	Louis C. Skinner Jr., C. Gables	Kenneth J. Weiler, St. Petersburg	
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Neurology and Psychiatry			
Ob. and Gynec. Society	S. Carnes Harvard, Brooksville	T. Bert Fletcher Jr., Tallahassee	Nov. 30-Dec. 1, '57
Ophthal. & Otol., Soc. of	Carl S. McLemore, Orlando	Joseph W. Taylor Jr., Tampa	Jan. 58
Orthopedic Society	Robert P. Keiser, Coral Gables	Elwin G. Neal, Miami	
Pathologists, Society of	Wray D. Storey, Tampa	Clarence W. Ketchum, Tallahassee	
Pediatric Society			
Plastic & Reconstructive Surgery	Geo. W. Robertson III, Miami	Bernard L. N. Morgan, Jax	
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Radiological Society	Donald H. Gahagen, Ft. L'derdale	Russell D. D. Hoover, W. P. Bch.	
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Pharmaceutical Assoc., State	Wesley D. Owens, Jacksonville	Mr. R. Q. Richards, Ft. Myers	
Public Health Association	Mrs. Bertha King, Tampa	Clarence L. Brumback, W. P. B.	Ft. Lauderdale Oct. 31-Nov. 2, '57
Trudeau Society	Howard M. DuBose, Lakeland	Frank Cline Jr., Tampa	" " " "
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Woman's Auxiliary	Mrs. Perry D. Melvin, Miami	Mrs. Wendell J. Newcomb, Pensa.	Miami Beach, May 10-14,'57
American Medical Association	Dwight H. Murray, Napa, Calif.	Geo. F. Lull, Chicago	New York, June 3-7, 1957
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Southern Medical Association	W. Ray McKenzie, Balti., Md.	Mr. V. O. Foster, Birmingham	Miami Beach, Nov. 11-14, '57
Alabama Medical Association	Grady O. Segrest, Mobile	Douglas L. Cannon, Montgomery	
Georgia, Medical Assn. of	Hal M. Davison, Atlanta	David Henry Poer, Atlanta	
S. E. Hospital Conference	Mr. D. O. McClusky Jr. Tuscaloosa, Ala.	Mr. Pat Groner, Pensacola	
Southeastern Allergy Assn.	Clarence Bernstein, Orlando	Kath. B. MacInnis, Columbia, S.C.	Charleston, S.C., Nov. 1-2, '57
Southeastern, Am. Urological Assn.	Sidney Smith, Raleigh, N. C.	Robert F. Sharp, New Orleans	
Southeastern Surgical Congress	J. O. Morgan, Gadsden, Ala.	B. T. Beasley, Atlanta	
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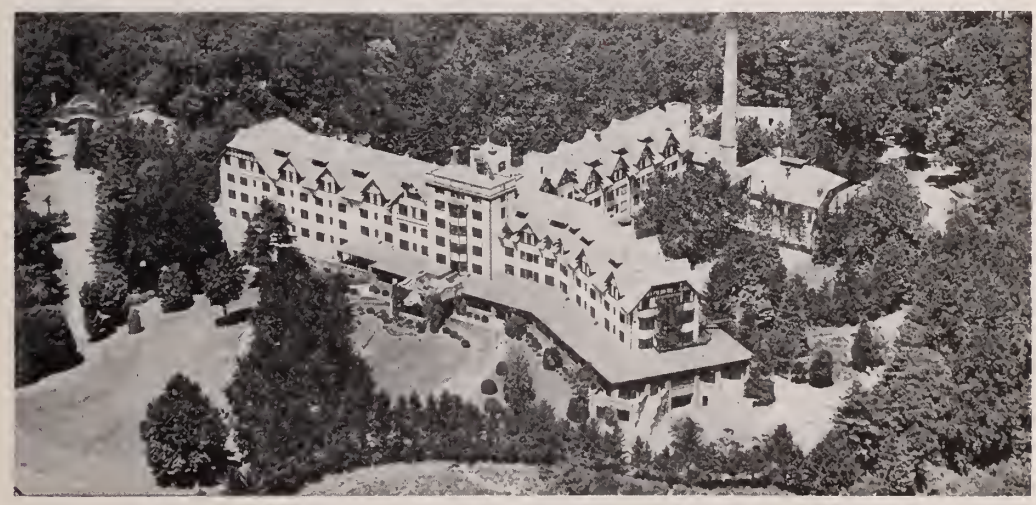

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JUN 2 1964	[illegible]
[illegible]	Foley, [illegible]